No. 14627

United States Court of Appeals

For the Ninth Circuit.

UNITED STATES OF AMERICA,

Appellant,

vs.

AMOS R. MORIN,

Appellee.

Transcript of Record

Appeal from the United States District Court for the District of Oregon

FILE

APR 11 1955

PAUL P. O'BRIEN, CL

Phillips & Van Orden Co., 870 Brannan Street, San Francisco, Calif.—3/11/55

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[Clerk's Note: When deemed likely to be of an important nature, errors or doubtful matters appearing in the original certified record are printed literally in italic; and, likewise, cancelled matter appearing in the original certified record is printed and cancelled herein accordingly. When possible, an omission from the text is indicated by printing in italic the two words between which the omission seems to occur.]

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In the District Court of the United States
for the District of Oregon

No. 7260—Civil

AMOS R. MORIN,

Plaintiff,

vs.

UNITED STATES OF AMERICA,

Defendant.

COMPLAINT

Comes now the plaintiff and for his cause of action complains and alleges as follows:

I.

That this action arises under Title 28, United States Code, Section 1346(b), as hereinafter more fully appears.

II.

That plaintiff resides in the City of Portland, State of Oregon, in the District of Oregon.

III.

That the tort claim for which plaintiff sues herein arises from the acts and ommissions hereinafter alleged which occurred at the City of Portland, State of Oregon, in the District of Oregon.

IV.

That at all times herein mentioned the Public Health Service was and now is a service in the Fed-

eral Security Agency of the United States of America.

V.

That at all times hereinmentioned plaintiff was by reason of his employment as a civilian by the United States Army as a Seaman, entitled to receive medical care from the said United States Public Health Service.

VI.

That on or about the 10th day of June, 1952, plaintiff was injured in an accident not connected with his employment, and received among other injuries a compound fracture of the tibia and laceration of the shin.

VII.

That thereafter on the said 10th day of June, 1952, on or about 1:45 o'clock in the afternoon of said day plaintiff was received into the Physicians and Surgeons Hospital located in Portland, Oregon, and remained there on the 10th, 11th, and the forenoon of the 12th day of June, 1952, said hospital being designated by the said Public Health Service as the station of the service for hospital treatment in the City of Portland, Oregon.

VIII.

That at said time and place the defendant through its agents, servants and employees acting as physicians of the said Public Health Service entered upon and assumed the relationship of physician to the plaintiff herein as patient and pursuant to said relationship examined plaintiff and undertook to

treat and care for plaintiff and impliedly agreed to exercise and use a reasonable degree of professional skill and diligence in the diagnoses, care and treatment of plaintiff.

IX.

That at the time and place at which defendant undertook to diagnose, treat, and care for plaintiff as aforesaid, plaintiff was suffering from the injuries aforesaid, and in particular the said severe compound fracture of the lower third of the tibia of the left leg, which caused the said broken bone to protrude through plaintiff's skin and to expose plaintiff to infection and that at the site of said compound fracture there was dirt and other foreign matter; that the defendant did diagnose, treat and care for the defendant, but that the defendant in treating plaintiff did so in a negligent and careless manner.

X.

That as a direct and proximate cause of the negligence, carelessness and failure of the defendant to exercise a reasonable degree of professional skill, knowledge and care customarily exercised by physicians in the City of Portland, County of Multnomah, State of Oregon, plaintiff suffered infection of the bone of the tibia of the left leg, poor healing of the original wound, especially marked impairment of the circulation of the blood in said left leg, and was required to undergo eight further surgical procedures in addition to the initial setting of the said fracture to the left tibia, which was made after defendant's care and treatment of plaintiff in Portland,

County of Multnomah, State of Oregon, had ended and that plaintiff's healing from said subsequent operative procedures were greatly impaired, and that plaintiff has further suffered a chronic osteomyelitis of the said left tibia; that plaintiff will be required to undergo further operations and that said injuries to the left tibia are painful, disabling and disfiguring and that plaintiff does now suffer from said osteomyelitis and impairment of the circulation of the blood in the left leg, and an unhealed open wound in said left leg, disability, pain and suffering, and will continue to suffer therefrom for an indefinite length of time in the future, all to plaintiff's general damage in the amount of $65,000.00.

XI.

That as a proximate result of the negligence and carelessness of the defendant aforesaid, plaintiff has been required to undergo hospitalization, and obtain the treatment of physicians and surgeons and to purchase drugs and medicines, reasonable value of such services and medicines being $339.60 all to plaintiff's special damage in said amount.

XII.

That prior to the time of the injury of plaintiff and the negligence of defendant as aforesaid, plaintiff was an able-bodied man earning $380.00 per month, and that as a result of said injuries the plaintiff has been unable to work and is unable to work at the time of the signing of this said complaint, and that as a sole and proximate result of

the negligence of defendant aforesaid plaintiff has lost the amount of $6,460.00 in wages, all to plaintiff's special damage in said amount.

Wherefore, plaintiff demands judgment against the defendant in the amount of $65,000.00 general damages, and the sum of $339.60 special damages and the further sum of $6,460.00 special damages and for his costs and disbursements herein incurred, and for reasonable attorneys' fees herein.

/s/ JOHN D. RYAN,
Of Attorneys for Plaintiff.

[Endorsed]: Filed November 17, 1953.

[Title of District Court and Cause.]

ANSWER

Comes now defendant by and through Henry L. Hess, United States Attorney for the District of Oregon, and Victor E. Harr, Assistant United States Attorney, and by direction of the Attorney General of the United States, and for answer to plaintiff's complaint herein admits, denies and alleges as follows:

1. Admits the allegation of Paragraph I.

2. Admits the allegation of Paragraph II.

3. Defendant has no knowledge of the facts alleged in Paragraph III thereof and therefore denies the same and the whole thereof.

4. Admits the allegation of Paragraph IV except that defendant alleges that the Federal Security Agency was superseded by and is now known as the Department of Health, Education and Welfare.

5. Admits the allegations of Paragraph V except that defendant alleges that said medical care was to be furnished by the Department of Health, Education and Welfare.

6. Admits the allegations of Paragraph VI.

7. Admits the allegations of Paragraph VII except that defendant affirmatively alleges that plaintiff remained in said hospital until about 8:00 a.m. on June 12, 1952, and alleges further that the said hospital was under contract with the Department of Health, Education and Welfare rather than with the Public Health Service.

8. Admits the allegations of Paragraph VIII except that defendant alleges that the Public Health Service was superseded by an agency of the government designated as Department of Health, Education and Welfare.

9. Answering Paragraph IX defendant admits that defendant did diagnose, treat and care for plaintiff at the Physicians and Surgeons Hospital in Portland, Oregon, and elsewhere; admits further that plaintiff sustained a compound fracture at the junction of the middle and lower third of the tibia of the left leg and other injuries; admits further that a portion of the said broken bone protruded through plaintiff's skin where it was exposed to

infection and contamination; admits further that it did diagnose, treat and care for plaintiff but denies each and every other allegation, matter and thing in said paragraph contained and the whole thereof.

10. Denies each and every allegation, matter and thing contained in Paragraph X and the whole thereof and specifically denies that plaintiff was damaged in the sum of $65,000.00 or in any other amount.

11. Denies each and every allegation, matter and thing contained in Paragraph XI and the whole thereof and specifically denies that plaintiff was damaged specially in the sum of $339.60 or in any other amount.

12. Answering Paragraph XII defendant asserts that it has no knowledge of whether or not plaintiff was able-bodied prior to the accident hereinbefore referred to and has no knowledge as to whether or not plaintiff has been unable to work as set forth in said Paragraph XII and puts plaintiff to proof thereon, and further that defendant specifically denies that plaintiff has lost the amount of $6,460.00 or any other sum in wages because of any negligence of defendant.

For a further and separate answer and defense, defendant alleges as follows:

1. That during the period that defendant, acting by and through the Department of Health, Education and Welfare, was rendering treatment to

plaintiff in the Public Health Service Hospital in Seattle following his removal to Seattle on June 12, 1952, plaintiff failed and refused to cooperate with defendant and defendant's medical attendants, and failed and refused to accept treatment at said hospital from and after August 13, 1952, against the advice and desire of the medical staff of defendant in attendance at said hospital at said time, and did on said August 13, 1952, notwithstanding the advice of defendant's said doctors as aforesaid, removed himself from said hospital; that defendant further alleges that any residual disability, if any, suffered by plaintiff as alleged in his complaint was proximately due to his own negligence or negligence of other medical or surgical advice and treatment contracted for by plaintiff individually.

Wherefore, defendant, having fully answered plaintiff's complaint, prays that the same be dismissed and held for naught and that defendant recover its costs and disbursements herein incurred.

HENRY L. HESS,
United States Attorney for
the District of Oregon;

/s/ VICTOR E. HARR,
Assistant United States
Attorney.

Affidavit of Service by Mail attached.

[Endorsed]: Filed January 15, 1954.

[Title of District Court and Cause.]

PRETRIAL ORDER

This cause came on regularly for pretrial conference before the undersigned Judge of the above-entitled Court, plaintiff appearing by John D. Ryan of Ryan & Pelay, and defendant appearing by C. E. Luckey, United States Attorney for the District of Oregon, and Victor E. Harr, Assistant United States Attorney.

Agreed Facts

The following facts have been agreed upon by the parties and require no proof:

1. The court has jurisdiction of the within cause by virtue of Title 28, Section 1346(b), United States Code.

2. Plaintiff is a resident and inhabitant of the City of Portland, County of Multnomah, State of Oregon, and within the jurisdiction of this court.

3. At all times herein mentioned the Public Health Service of the United States of America was an agency of the defendant, United States of America, and that said Public Health Service was superseded by and is now known as the Department of Health, Education and Welfare.

4. During all times herein mentioned plaintiff was in the employment of defendant as a seaman, to wit: a third mate aboard the U. S. Dredge Wahkiakum, and as such was entitled to receive medical care from the said Public Health Service.

5. On or about the 10th day of June, 1952, plaintiff was injured in an accident not connected with his employment, and received among other injuries, a compound comminuted fracture of the lower third of the left tibia, two simple fractures of the left fibula, and a compression fracture of the body of the second lumbar vertebrae, and that by virtue of the compound cominuted fracture of the left tibia, there were two lacerations of the skin, and that the bone of the fractured tibia was exposed.

6. Thereafter and on the 10th day of June, 1952, at or about 1:15 p.m. on said day, plaintiff was received into the Physicians and Surgeons Hospital located in Portland, Oregon, and remained in said Physicians and Surgeons Hospital until June 12, 1952, at which time plaintiff was removed from said hospital by defendant and transported by ambulance to the United States Marine Hospital, Seattle, Washington, for treatment.

7. During the times herein involved, by invitation, bid and award, the Physicians and Surgeons Hospital located at 1927 N.W. Lovejoy Street in Portland, Oregon, was under contract with the Federal Security Agency, Public Health Service, of defendant to render hospital care for patients of the United States Public Health Service, which said hospital care was to consist of the best treatment afforded by said hospital, including subsistence, nursing, medical and surgical attendance (meaning such treatment, including surgery, as is usually furnished by the house staff of the hospital and necessary surgical dressings). (Plaintiff con-

tends that the agreed fact as herein set forth is immaterial to the issues herein involved.)

8. That at said time and place the defendant through its agents, servants and employees acting as physicians under the direction of the said Public Health Service entered upon and assumed the relationship of physician to the plaintiff herein as patient and pursuant to said relationship examined plaintiff and undertook to treat and care for plaintiff and impliedly agreed to exercise and use a reasonable degree of professional skill and diligence in the diagnosis, care and treatment of plaintiff.

9. That defendant did diagnose, treat and care for plaintiff's injuries as aforesaid at the Physicians and Surgeons Hospital in Portland, Oregon, and elsewhere.

Plaintiff's Contentions

1. Plaintiff contends that at said time and place, the defendant undertook to diagnose, treat and care for plaintiff as aforesaid, plaintiff was suffering from the injuries as aforesaid, and in particular the said severe compound fracture of the lower third of the tibia of the leg, which caused the said broken bone to protrude through plaintiff's skin and to expose plaintiff to infection and that at the site of said compound fracture, there was dirt and other foreign matter; that the defendant did diagnose, treat and care for the defendant, but that the defendant in treating plaintiff did so in a negligent and careless manner in the following particulars

proximately causing injuries to the plaintiff as are hereinafter more fully set forth.

(a) In failing to render to plaintiff immediate, adequate and proper medical and surgical treatment; cleanse debridment and closure of the wounds at the site of said comminuted compound fracture of the left tibia.

(b) In failing to provide plaintiff with a proper and adequate or any splint for said left leg.

(c) In unnecessarily transporting and moving plaintiff from Portland, Oregon, to Seattle, Washington, at a time when same could not be done with safety to plaintiff.

(d) In failing to exercise the degree of care and skill ordinarily exercised by physicians in Portland, Oregon, and like communities, in the treatment of comminuted compound fractures of the left tibia.

(e) In failing to obtain proper and adequate treatment for plaintiff and particularly for the treatment of the said comminuted compound fracture of the left tibia.

(f) In failing to properly advise the plaintiff to obtain proper, timely and adequate treatment in Portland, Oregon, for said injuries and more particularly the said comminuted compound fracture of the tibia.

2. The plaintiff contends that as a direct and proximate cause of the negligence, carelessness and failure of the defendant as heretofore set forth,

plaintiff suffered infection of the bone of the tibia of the left leg, poor healing of the original wound, especially marked impairment of the circulation of the blood in said left leg, and was required to undergo sixteen further surgical procedures after the initial setting of the said fracture to the left tibia, which was made after defendant's care and treatment of plaintiff in Portland, County of Multnomah, State of Oregon, had ended, and that plaintiff's healing of his original injury to the left lower leg and from said subsequent operative procedures was, and now is, greatly impaired, and that plaintiff has further suffered a recurrent chronic osteomyelitis of the said left tibia; that plaintiff will be required to undergo further operations and that said injuries to the left tibia are painful, disabling and disfiguring and that plaintiff does now suffer from said osteomyelitis and impairment of the circulation of the blood in the left leg and skin, with diminished regenerative quality, scarring of said left leg, and scars and wounds on the calf of the right leg and left thigh at the donor sites of skin for grafting at said left tibia wound site, and an unhealed open wound in said left leg, and demineralization of said left leg and ankle and weakness and crippling of said ankle, disability, pain and suffering, and will continue to suffer therefrom for an indefinite length of time in the future, all to plaintiff's general damage in the amount of $65,000.00.

3. That as a proximate result of the negligence and carelessness of the defendant aforesaid, plain-

tiff has been required to undergo hospitalization, and obtain the treatment of physicians and surgeons and to purchase drugs and medicines, the reasonable value of such services and medicines being $523.75, all to plaintiff's special damage in said amount.

4. That prior to the time of the injury of plaintiff and the negligence of defendant as aforesaid, plaintiff was an able-bodied man and was gainfully employed, and that as a result of said injuries the plaintiff was unable to work for the periods and at the rates hereinafter set forth, and that as a sole and proximate result of the negligence of defendant aforesaid plaintiff has lost the amount of $6,388.32 in wages, all to plaintiff's special damage in said amount, which is set forth in the amounts and dates as follows, to wit:

Date	Rate Per Hour	Hours Lost	
6-11-52 to 9-18-52	$2.10	598	$1,255.80
9-18-52 to 10- 2-52	$2.10	78	$ 163.80
10- 2-52 to 12- 6-52	$2.10	372	$ 781.20
1-25-53 to 2-20-53	$2.10	160	$ 336.00
4-27-53 to 7-15-53	$2.28	416	$ 948.48
9-11-53 to 3-31-54	$2.52	1152	$2,903.04
			$6,388.32

5. Plaintiff denies each and every affirmative contention of the defendant.

Defendant's Contentions

1. Answering Plaintiff's Contention No. 1, defendant admits that it did undertake to diagnose, treat and care for plaintiff as set forth in the Agreed Facts herein, and admits the injuries suffered by plaintiff as therein set forth, but denies that defendant was negligent in any manner set forth therein or otherwise.

2. Answering Plaintiff's Contention No. 2, defendant denies the same and the whole thereof and particularly denies that plaintiff was damaged in the sum of $65,000.00 or in any other amount.

3. Answering Plaintiff's Contention No. 3, defendant denies each and every contention made therein and the whole thereof, and particularly denies that plaintiff was damaged specially in the sum of $523.75 or in any other amount.

4. Answering Plaintiff's Contention No. 4, defendant admits that prior to plaintiff's accident, plaintiff was gainfully employed, but denies each and every remaining contention therein, and particularly denies that plaintiff suffered loss of wages in the sum of $6,388.32 as a result of any negligence of this defendant, nor was he damaged in any other amount.

5. Defendant contends that during the period that defendant, acting by and through the United States Public Health Service, was rendering treatment to plaintiff in the Public Health Service Hospital in Seattle following his removal to Seattle on

June 12, 1952, plaintiff failed and refused to cooperate with defendant and defendant's medical attendants, and failed and refused to accept treatment at said hospital from and after August 13, 1952, against the advice and desire of the medical staff of defendant in attendance at said hospital at said time, and did on said August 13, 1952, notwithstanding the advice of defendant's said doctors as aforesaid, remove himself from said hospital, and in writing released said hospital and staff from any and all responsibility in connection with his said injuries or the outcome thereof.

6. The defendant further contends that residual disability, if any, which plaintiff may have suffered after leaving the United States Public Health Service Hospital in Seattle, Washington, was proximately due to his own negligence, the negligence of other medical or surgical treatment contracted for and received by plaintiff, or from cause or causes unknown to this defendant.

Issues to Be Determined

The issues to be determined on the trial of this cause are:

1. Was the defendant negligent in any of the respects alleged by the plaintiff? If so, was such negligence the proximate cause of injuries, if any, received by plaintiff?

2. What was the nature and extent of the injuries which resulted from the negligence of the defendant, if any?

3. Does the contributory negligence alleged by the defendant on the part of the plaintiff constitute a defense to the claim of plaintiff against the defendant, or any part thereof?

4. In the event that said contributory negligence is considered a defense to the claim of plaintiff, or any part thereof, was plaintiff guilty of contributory negligence which proximately caused the injuries, if any, of which plaintiff is complaining, or any part thereof?

5. Does negligence, if any, on the part of the plaintiff which did not contribute to the cause but which may have aggravated the injuries, if any, constitute a proper matter of defense to all or part of plaintiff's alleged damage?

6. What was the nature and extent of the damages sustained by plaintiff, if any?

EXHIBITS

Plaintiff's

No. 1. Photostatic copy of record of treatment of Amos Morin at Physicians and Surgeons Hospital, June 10 through June 12, 1952.

Nos. 2a to b, incl. X-rays of Amos Morin taken at Physicians and Surgeons Hospital, June 10, 1952.

No. 3. Photostatic copy of hospital record of Amos Morin of United States Marine Hospial, Seattle, Washington.

Nos. 4a to j, incl. X-rays of Amos Morin, United States Marine Hospital, Seattle, Washington.

Plaintiff's Exhibits—(Continued)

Nos. 5a to b. X-rays dated 8/19/52—Dr. Thorup.

No. 6. Hospital record of Amos Morin at Providence Hospital, Portland, Oregon.

No. 7. X-rays of Amos Morin, Providence Hospital, Portland, Oregon.

No. 8. Hospital record of Amos Morin, St. Vincent's Hospital.

No. 9. X-rays of Amos Morin, St. Vincent's Hospital, Portland, Oregon.

No. 10. Hospital record of Amos Morin, United States Veterans Hospital, Portland, Oregon.

No. 11. X-rays of Amos Morin, United States Veterans Hospital, Portland, Oregon.

No. 12. Record of history of treatment of Amos Morin by Dr. Howard Cherry.

No. 13. Campbell's Operative Orthopedics, Volume I, C. V. Mosby, St. Louis, 1949.

No. 14. Pictorial Handbook of Fracture Treatment, Compere - Banks - Compere. The Year Book Publishers, Inc., Chicago, Illinois, Second Edition.

No. 15. Deposition of Lee A. Craig as adverse witness.

No. 16. Deposition of Constantine Otto Schneider.

Defendant's

No. 17. Specimen of bone chips, 7/11/52.

No. 18. Payroll and employment records, Dredge Wahkiakum.

No. 19. Textbook of Surgery—Christopher.

No. 20. USPHS Outpatient Clinical Records.

Defendant's Exhibits—(Continued)

Nos. 21a and b. USPHS X-rays, Nov. 12 and 26, 1952.

No. 22. Attorneys' Textbook of Medicine, Roscoe N. Gray, M.D.

Nos. 23a to e, incl. X-rays by Dr. Berg.

No. 24. Report and office memorandum of Dr. Warren C. Hunter.

No. 25. Office notes and memorandum of Dr. Richard Berg.

Plaintiff's

No. 26. Statements covering plaintiff's costs:

a.	St. Vincent's Hospital	$ 71.25
b.	Providence Hospital	177.00
c.	Dr. Thorup	111.00
d.	Dr. Cherry	164.50

Conclusion

This pretrial order has been formulated after a conference between the attorneys for the respective litigants. There are no issues of law or fact except as embodied in this order and this order supersedes the pleadings as to issues of fact and law. This order will control the course of the trial and shall not be amended except by consent of the parties and the Court or by the Court to prevent manifest injustice.

Dated at Portland, Oregon, this 21st day of July, 1954.

/s/ CLAUDE McCOLLOCH,
U. S. District Judge.

The Foregoing Pretrial Order Is Hereby Approved:

/s/ JOHN D. RYAN, of
Attorneys for Plaintiff.

/s/ VICTOR E. HARR,
Assistant United States Attorney for the District of Oregon, of Attorneys for Defendant.

[Endorsed]: Filed in Open Court July 21, 1954.

[Title of District Court and Cause.]

MEMORANDUM

The patient was admitted to the hospital at 1:45 p.m., but a Public Health surgeon did not see him until the following morning. This was gross inattention.

The impression is overpowering that the Public Health Service intended from the beginning to send the plaintiff to Seattle for the needed surgery. Their major interest was in the plaintiff's general condition—whether he would be able to stand the trip to Seattle. This explains the failure of the Public Health surgeons to see the patient the day of the accident, as might normally be expected. And, of course, no consideration was given to the alternative procedures detailed by defendant's own orthopedic expert, Dr. Berg.

Dr. Cherry testified that the osteomyelitis resulted

from the failure to close the wound at Portland, and I accept his opinion.

Findings of Fact may be submitted, with the amount of general damages left blank.

Dated August 4, 1954.

/s/ CLAUDE McCOLLOCH,
Judge.

[Endorsed]: Filed August 4, 1954.

[Title of District Court and Cause.]

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This cause having come on regularly for trial before the above-entitled Court before the Honorable Claude McColloch presiding, on the 21st day of July, 1954, plaintiff appearing in person and by and through his attorneys, John D. Ryan and Thomas H. Ryan of Ryan & Pelay, and defendant appearing by and through its attorneys, C. E. Luckey, United States District Attorney, and Victor E. Harr, Deputy United States District Attorney, and the Court having heard testimony and received evidence on behalf of both parties and being fully advised in the premises, the Court finds as follows:

I.

That plaintiff was duly and regularly admitted as a patient of the Public Health Service of the United

States, an agency of the defendant, United States of America, for treatment of injuries received, plaintiff being entitled to said service the date of admission to treatment being June 10, 1952, and the place of admission being Physicians' and Surgeons' Hospital located at Portland, Oregon, which hospital was under contract with the Federal Security Agency, Public Health Service of defendant to render care in such cases.

II.

That defendant through its agents, servants and employees undertook to examine, treat and care for plaintiff and to exercise a reasonable degree of professional skill and diligence in the diagnosis, care and treatment of patient.

III.

That at said time and place the plaintiff was suffering from serious personal injuries, among them a severe compound fracture of the lower third of the tibia of the leg with a broken bone protruding through plaintiff's skin and exposed to infection at the site of said compound fracture and that at said site there was dirt and other foreign matter and defendant did diagnose, treat and care for plaintiff but defendant in treating plaintiff did so in a negligent, careless manner in the following particulars proximately causing injuries to plaintiff:

(a) In failing to render to plaintiff immediate, adequate and proper medical and surgical treatment; cleanse debridement and closure of the

wounds at the site of said comminuted compound fracture of the left tibia.

(b) In failing to exercise the degree of care and skill ordinarily exercised by physicians in Portland, Oregon, and like communities, in the treatment of comminuted compound fractures of the left tibia.

IV.

That as a direct and proximate result of said negligence and carelessness plaintiff suffered infection of the bone of the tibia of the left leg, poor healing of the original wound, especially marked impairment of the circulation of the blood in said left leg, and was required to undergo sixteen further surgical procedures after the initial setting of the said fracture to the left tibia, which was made after defendant's care and treatment of plaintiff in Portland, County of Multnomah, State of Oregon, had ended, and that plaintiff's healing of his original injury to the left lower leg and from said subsequent operative procedures was, and now is, greatly impaired, and that plaintiff has further suffered a recurrent chronic osteomyelities of the said left tibia; that plaintiff will be required to undergo further operations and that said injuries to the left tibia are painful, disabling and disfiguring and that plaintiff does now suffer from said osteomyelities and impairment of the circulation of the blood in the left leg and skin, with diminished regenerative quality, scarring of said left leg, and scars and wounds on the calf of the right leg and left thigh at

the donor sites of skin for grafting at said left tibia wound site, and an unhealed open wound in said left leg, and demineralization of said left leg and ankle and weakness and crippling of said ankle, disability, pain and suffering, and will continue to suffer therefrom for an indefinite length of time in the future and that plaintiff will be permanently disabled as a result thereof.

V.

That as a result of the negligence of defendant, plaintiff incurred medical and hospital bills in the sum of $523.75.

VI.

That as a direct and proximate result of the negligence and carlessness of defendant, plaintiff lost wages amounting to $4,187.52.

VII.

That plaintiff was not guilty of contributory negligence nor of any negligence causing an aggravation of the injuries sustained.

VIII.

That plaintiff is entitled to recover the sum of $523.75 for medical and hospital expenses, and the further sum of $4,187.52 loss of wages, totaling $4,711.27 as special damages.

IX.

That plaintiff is entitled to recover the sum of $45,000 general damages and is entitled to costs assessed at $.....

And as conclusions of law from the foregoing facts, plaintiff is entitled to judgment against the defendant in the sum of $4,711.27 special damages, and the further sum of $45,000 general damages, and his costs and disbursements taxed at $.....

Dated this 10th day of August, 1954, at Portland, Oregon.

/s/ CLAUDE McCOLLOCH,
Judge.

Service of Copy acknowledged.

[Endorsed]: Filed August 10, 1954.

In the United States District Court
for the District of Oregon

Civil No. 7260

AMOS MORIN,

Plaintiff,

vs.

UNITED STATES OF AMERICA,

Defendant.

JUDGMENT

The above-entitled cause having duly come on for trial before the Honorable Claude McColloch, Judge of the above-entitled Court, on the 21st day of July, 1954, the plaintiff appearing by and through Thomas H. Ryan and John D. Ryan of his Attorneys, Ryan & Pelay, and the defendant appearing

by and through C. E. Luckey, United States Attorney for the District of Oregon and Victor E. Harr, Assistant United States Attorney, and evidence having been submitted and witnesses examined by plaintiff and defendant, and after hearing arguments of counsel, and the Court being fully informed in the premises, the Court made and entered herein on August 10, 1954, certain findings of facts and conclusions of law;

Now, Therefore, based upon the said findings and conclusions,

It Is Hereby Ordered, Adjudged and Decreed that plaintiff have judgment against the defendant in the amount of $45,000.00, general damages, and $4,711.27, special damages, together with interest at the legal rate, and for plaintiff's costs taxed at $48.98; and it is further ordered that plaintiff's attorneys, Ryan and Pelay, be awarded attorneys' fees in the amount of $9,942.25, and that said attorneys' fees be deducted from the amount of the judgment herein given to plaintiff and paid unto the said attorneys of plaintiff, and such judgment is hereby entered in favor of the plaintiff and against the defendant.

/s/ CLAUDE McCOLLOCH,
Judge.

Dated this 26th day of August, 1954.

[Endorsed]: Filed August 26, 1954.

[Title of District Court and Cause.]

NOTICE OF APPEAL

To: Amos Morin, plaintiff and T. H. Ryan of Ryan & Pelay, attorneys for Plaintiff:

Notice is hereby given that the United States of America, defendant above named, hereby appeals to the United States Court of Appeals for the Ninth Circuit from the final Judgment entered in this action on the 26th day of August, 1954, in favor of plaintiff and against defendant.

Dated this 25th day of October, 1954, at Portland, Oregon.

C. E. LUCKEY,
United States Attorney for
the District of Oregon.

/s/ C. E. LUCKEY.

[Endorsed]: Filed October 25, 1954.

[Title of District Court and Cause.]

ORDER

This matter coming on to be heard ex parte this day upon motion of defendant, through its attorneys, C. E. Luckey, United States Attorney for the District of Oregon, and Victor E. Harr, Assistant United States Attorney, for an order extending time for the filing of the record on appeal and docketing the within action in the United States Court of Appeals for the Ninth Circuit, to enable the Department of Justice to have additional time to consider

said appeal, and the Court being fully advised in the premises, it is hereby

Ordered that the time for filing the within appeal and docketing the action be and it is hereby extended to ninety days from the first date of the Notice of Appeal.

Dated this 2nd day of December, 1954, at Portland, Oregon.

/s/ CLAUDE McCOLLOCH,
District Judge.

[Endorsed]: Filed December 2, 1954.

[Title of District Court and Cause.]

ORDER

This matter coming on to be heard on motion of the defendant, United States of America, through its attorneys, C. E. Luckey, United States Attorney for the District of Oregon, and Victor E. Harr, Assistant United States Attorney, for an order directing the Clerk of the above-entitled Court to transmit in their original form all exhibits introduced in the within cause to the Clerk of the United States Court of Appeals for the Ninth Circuit, and it appearing to the Court that the parties, through their respective attorneys, have so stipulated, and the Court being advised in the premises, it is hereby

Ordered that the Clerk of the above-entitled Court transmit to the Clerk of the United States Court of Appeals for the Ninth Circuit, in their original form, all exhibits introduced in the trial of the above-entitled cause.

Dated at Portland, Oregon, this 14th day of January, 1955.

/s/ CLAUDE McCOLLOCH,
District Judge.

[Endorsed]: Filed January 14, 1955.

United States District Court,
District of Oregon
Civil No. 7260

AMOS R. MORIN,

Plaintiff,

vs.

UNITED STATES OF AMERICA,

Defendant.

Before: Honorable Claude McColloch, Judge.

Appearances:

THOMAS H. RYAN, and
JOHN D. RYAN,
Of Attorneys for Plaintiffs.

C. E. LUCKEY,
United States Attorney;

VICTOR E. HARR,
Assistant United States Attorney, of Attorneys for Defendant.

TRANSCRIPT OF TESTIMONY AND PROCEEDINGS

July 21, 1954, A.M.

Mr. John D. Ryan: Does your Honor desire an opening statement?

The Court: If you wish to make one. I have read the file and the deposition. [1*]

Mr. John D. Ryan: If your Honor has familiarized yourself with the file, I am sure you have an understanding of the case as far as we are concerned.

Mr. Harr: We will waive opening statements.

DAVID AMOS MORIN

produced as a witness on behalf of Plaintiff, and being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. John D. Ryan:

Q. Are you the son of Amos R. Morin, the plaintiff in this case? A. Yes, I am.

Q. What is your age? A. I am 16.

Q. You live at home with your folks?

A. Yes, sir; I do.

Q. Where is your home?

A. 4640 Northeast 30.

Q. Do you attend school?

A. Yes, sir; I do.

Q. Where do you go to school?

A. Central Catholic. [2]

*Page numbering appearing at top of page of original Reporter's Transcript of Record.

(Testimony of David Amos Morin.)

Q. Do you recall an accident at your home on June 10, 1952? A. Yes, sir; I do.

Q. Would you tell the Court: Did you see your father fall on that date?

A. I was in back of the house when it happened, but I heard him cry when he fell, and I came around the house and he was lying there under this ladder, and he helped himself—I helped him. He had his leg out over the end of the ladder.

Q. He had fallen from up on a ladder?

A. Yes.

Q. Where was the ladder sitting?

A. On the side of the house. He was painting at the time.

Q. When you came to your father, he had already fallen?

A. Yes. He was lying on the ground. Well, he was sitting there, trying to pull himself out. He had his hands on the ground, but the ladder was quite long, and he had some difficulty, so I lifted the ladder and he rolled on his stomach.

Q. Was his leg in between the rungs of the ladder? A. Yes.

Q. Was his body lying right on the sidewalk?

A. He landed on the lawn.

Q. Did you have reason to look at your father's leg?

A. Yes, sir; I did. I noticed it right away.

Q. Which leg was injured? Would you describe what you saw?

A. It was his left leg. There was blood all over

(Testimony of David Amos Morin.)

his [3] stocking and the bone was protruding out about two inches or about two and a half inches. You could see the white of the bone very clearly. It looked like it had been ripped right out through his leg. There was blood all over his stocking and his pants were bloody, so you could see it.

Q. Did you move your father from that spot?

A. He moved himself. I never touched him, but he tried to move. I tried to comfort him and he told me to get a blanket for him. I covered him with a blanket, and he told me to get a doctor and call an ambulance.

Q. Did you do that?

A. Yes, sir; I did right away.

Q. What had your father been doing that morning?

A. He had been painting that morning. He got up quite early and started painting the house.

Q. Had your father been in good health prior to his fall?

A. He was in very good health. He assisted me in sports. I had been playing football that season and he had helped me train for it. I had been hunting with him that fall, the fall before, and we had played baseball, and he participated in sports and took care of a large garden. He did most of the digging, but I helped him a little in the garden. He was trying to paint the outside of the house when he fell.

Q. How many brothers and sisters have you?

A. I have four older sisters and one younger

(Testimony of David Amos Morin.)
brother. [4]

Q. Is your father able to engage with you in any sports at this time?

A. He can't move—he can't run. He can stand and throw, but that is about it. He can't participate like he used to.

Q. Have you been able to go hunting together since he had the injury?

A. Well, we go, but he sits and I do all the hunting. I put him on a rock and I do the hunting.

Mr. John D. Ryan: Thank you.

Cross-Examination

By Mr. Harr:

Q. I have one or two questions. What time of day did this happen?

A. It was in the morning, if I remember right; it was right around 10:30 or 11:00 o'clock.

Q. Are you sure it was that early?

A. It seems to me it was. It has been quite a while.

Q. Someone informed me—it is hearsay, of course, as far as I am concerned—that it was about 12:30. Would there be any doubt in your mind as to the time?

A. There would be doubt in my mind about the time, because he had gotten up that morning and it was clouded over. It started to rain, and there was a time you couldn't tell by the sun or anything. [5]

Q. You were not paying any particular attention to the time yourself? A. No.

(Testimony of David Amos Morin.)

Q. Did the ambulance come quite soon after you called?

A. Well, it took longer—he said he could have come sooner, but my sister called him—she called him right after he fell, but she never told him it was an emergency, and he said he could have come quicker. It just took about three or four minutes to get there.

Q. Did you have a family doctor at that time?

A. Yes, we did. I went after him, but he was out to lunch.

Q. You left word with him?

A. I left word with the doctor across the street.

Q. What is the doctor's name?

A. Dr. Done.

Q. How is that? A. I think it is D-o-n-e.

Q. Does he live across the street from you?

A. Across the street from Dr. Thorup.

Q. Did you go to the hospital with your father?

A. No, my mother came home from work and she went with him.

Q. You say when you went around the house you examined his leg?

A. Yes. I looked at it quite closely.

Q. Was his pant leg up at that time, or did you pull it up? [6]

A. No, it was up. I didn't want to touch him.

Q. His leg, you said, was stuck through the rungs of the ladder?

A. When he had fallen, yes. It looked like, on the way down, his leg had went through.

(Testimony of David Amos Morin.)

Q. Was he lying on his stomach? How was he lying? On his stomach or back?

A. He was lying on his back. He fell on his back. When I took him out of the ladder, I mean, he turned over; he rolled over with the ladder. After I took it out, he was lying on his stomach.

Q. As you pulled the ladder out, he continued to lie on his back?

A. No, he rolled over on his stomach.

Q. Do you know how old your father was at that time? A. 43, I think.

Q. Had your father been to any doctors before that, to your knowledge?

A. Not that I know of. I don't think so.

Q. As far as you know, had he ever been to a doctor?

A. Yes, he had had ulcers a couple of years before that. He was up in Seattle with ulcers.

Q. He was treated first in Portland, wasn't he, by the U. S. Public Health Service, or do you know?

A. I think so. [7]

Q. Then he went to Seattle, to the Marine Hospital there? A. Yes.

Q. That is a Public Health Service Hospital?

A. Yes.

Q. At the time you came around to your father, when he was on the ground, you said first you heard him cry? A. Yes.

Q. Was that yelling for help?

A. No, he yelled as he came down the house; as the ladder slid down the house he yelled.

(Testimony of David Amos Morin.)

Q. He yelled at that time? A. Yes.

Q. And you came running around the house?

A. Yes.

Q. By the time you reached there he had reached the ground and the ladder was tangled up with him?

A. Yes, he was laying on the ground.

Q. Was there a crowd there then?

A. You could hear him all over the neighborhood and the neighbors came out right away.

Q. But he was not unconscious?

A. No, he wasn't. He directed us.

Q. He told you what to do? A. Yes.

Q. At that time did he complain of having pain in any part [8] of his body?

A. He said his leg hurt him. He said it was real sore. He couldn't move his leg or anything.

Q. At that time did he say anything about his back injury, about his back hurting him?

A. Yes, I asked him where it hurt and he said his back, but "mostly in my leg."

Mr. Harr: No further questions.

(Witness excused.) [9]

DALE MORIN

produced as a witness on behalf of Plaintiff, and being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. John D. Ryan:

Q. You are Amos Morin's son? A. Yes.

(Testimony of Dale Morin.)

Q. Would you tell the Court your age?

A. I am 14 now.

Q. Where do you go to school?

A. I will be going to Central Catholic.

Q. Where have you been going to school?

A. St. Charles.

Q. Were you at home the day your dad was hurt, June 10, 1952? A. Yes.

Q. Where were you when your father fell from the side of the house?

A. I was in back helping my brother plant corn.

Q. Which brother is that? A. David.

Q. Will you tell us what you did at that time?

A. We heard him holler, cry out, and we went around to the front and he was laying on the ground, down on the ground, and his leg was in the ladder. We helped him get his leg out of the ladder, and he directed us and we went—I went down with [10] my brother to get the doctor. Then we came back and a few minutes later the ambulance came.

Q. Did the doctor come at that time?

A. Dr. Done did.

Q. What did he do? Were you there when he came? A. He gave my father a shot.

Q. Did he do anything else?

A. Well, he put a tape on his head to show what was wrong, and then left—he said he had to go; he said he had another call to make.

Q. Do you remember what that tape said?

A. It said he had a compound fracture of the leg and a crooked vertebra in the back.

(Testimony of Dale Morin.)

Q. Did you look at your father or have reason to look at your father? A. Yes, sir; I did.

Q. To see what was the matter with him?

A. Yes. I saw his leg and the bone was sticking out.

Q. How was he lying on the ground there? Could you describe how he was lying?

A. He was laying on his back, and when we took the ladder out from under him and got his leg out, then he rolled over on his stomach.

Q. Did you look at his leg closely at that time?

A. Yes, I looked at it. You could see the bone was broken [11] and it was sticking out of the leg about two and a half inches.

Q. Can you show us on your own leg which side of the leg the bone was sticking out?

A. The bone was sticking out on this side of the leg.

Q. You are pointing to the outside?

A. Yes.

Q. The front part, is that where it was sticking out? A. Yes.

Q. Can you tell us what it looked like?

A. A big gash and quite a bit of blood and bone was sticking out about two and a half inches.

Q. Do you have any idea of the size of the gash or cut?

A. It was about two and a half or three inches long.

Q. Did the ambulance come soon after he fell?

(Testimony of Dale Morin.)

A. Quite soon, about three or four minutes.

Q. Did they take your father to the hospital right away?

A. Yes, if I remember right they did.

Q. Was your father active before this injury?

A. Very much so. We played sports, football—he did play baseball; he would participate with me in it.

Q. Is he able to do that now?

A. No. He can stand and throw the ball back and forth.

Q. Did you go to the hospital with your dad?

A. No, I didn't. [12]

Q. Did he ever play tennis with you boys?

A. Yes, he played quite a bit. He never played with us, but we watched him play with the girls, my sisters.

Q. How often would he do that?

A. About once a week; about every Sunday.

Q. Does he play tennis any more?

A. No, he does not, not at all.

Q. Did he ever go swimming with you?

A. Yes, he did.

Q. Has he been able to do that?

A. No, he has not been swimming.

Mr. John D. Ryan: That will be all. Thank you.

Cross-Examination

By Mr. Harr:

Q. You said the doctor came to your house?

A. Dr. Done did, yes.

(Testimony of Dale Morin.)

Q. I beg your pardon? A. Dr. Done.

Q. How is that spelled?

A. I think it is spelled D-o-n-e.

Q. That is the doctor from across the street?

A. He is across the street from Dr. Thorup.

Q. That is not across the street, then, from your house? A. No, it is not. [13]

Q. Dr. Thorup was not at home at the time and you went to Dr. Done's house? A. Yes.

Q. Dr. Done came and gave him a shot at the house?

A. Yes, he came to our house and gave him a shot.

Q. And you say he made out a little memorandum or note to the effect that it was a compound fracture of the leg and a fracture of the vertebra?

A. A crooked vertebra, yes.

Mr. Harr: No further questions.

Mr. John D. Ryan: That is all.

(Witness excused.) [14]

MRS. SHIRLEY CANNARD

produced as a witness on behalf of Plaintiff, and being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. John D. Ryan:

Q. Are you Mr. Amos Morin's daughter?

A. Yes, I am.

(Testimony of Mrs. Shirley Cannard.)

Q. Were you at the family home, Mr. Morin's home, on June 10, 1952?

A. We drove up shortly after it happened.

Q. You drove out to the house shortly after the accident happened, the accident that you have heard described by the other witnesses? A. Yes.

Q. Would you tell us what you observed?

A. We drove up, and one of the neighbors was coming across the street and he said, "Your dad is hurt." I looked over and Dad was lying there—part of his body was on the sidewalk and his head was in the flower bed. The rest of his legs were on the lawn. He—his leg was bent in over a rung of the ladder, and at that time he was lying more or less on his right side, and the bone was sticking out and there was blood all over, and the skin was all torn where it came through, because the bone was pointed.

At that time Dad had told the boys to go for [15] a doctor and told me to get an ambulance. I asked him which hospital he wanted to go to, and he told me—he didn't tell me, and so I thought he would probably want to go to Providence and I told the ambulance driver he would go to Providence, but he said, "No. I want to go to Physicians and Surgeons because my insurance is covered there, my insurance cover there." We had him covered up with some blankets. About that time the boys came back with Dr. Done and he made out a memorandum. I don't remember just what it said, but I know he did put something on it which would tell what kind of medicine he had given to my Dad. He told me to be sure

(Testimony of Mrs. Shirley Cannard.)

to tell the ambulance attendant that there may be something wrong with his back, to be careful of that.

Q. Did you go with your father to the hospital?

A. I went in the car, yes. I called my mother and she came home.

Q. You say your father was over on his side?

A. I believe he was lying on his right side.

Q. When did you arrive at the hospital?

A. Well, as I remember, the accident happened between 12:00 and 12:30. He was taken right to the hospital and I imagine it would take about 15 or 20 minutes to get to the hospital. The ambulance might do better than that. We went directly to the hospital.

Q. Did you go to the hospital after the ambulance did? [16] A. Yes, afterwards.

Q. How long afterwards did you arrive at the hospital?

A. Well, when we arrived there Dad was already —had already been taken in the emergency room, and we waited out in the lobby.

Q. When did you next see your father?

A. I didn't see him in his room. Mother and I believe my older sister were the only ones who got to see him in his room. They wheeled him into his room. I don't know whether they gave him any treatment or not. We just saw this blanket over him.

Q. About what time of day was that?

A. It could have been about 1:00 o'clock or 1:15. I am not definite as to the time.

(Testimony of Mrs. Shirley Cannard.)

Q. When did you next see your father?

A. I didn't see him for two weeks. I did not have the chance to go up to Seattle for two weeks, because I was going to school, so I didn't see him for about two weeks.

Mr. John D. Ryan: Thank you.

Cross-Examination

By Mr. Harr:

Q. I think Counsel asked you if you knew what time it was you arrived at the house, and I did not catch your answer?

A. I said probably between 12:00 and 12:30. I was going to [17] school at the University of Portland that summer. I believe it was on a school day, and we always got home around noontime.

Q. Had the accident just then happened?

A. It had just happened. They had just gotten the ladder from under his leg.

Q. You say a part of his body or torso was up on the sidewalk? A. Yes.

Q. Do you know whether or not he had been moved from the time the accident happened until you got there, other than removing the ladder?

A. I don't know if he had been moved or not or how much he was moved.

Q. Was the blanket under him or over him?

A. No, the boys had spread the blanket over him.

(Testimony of Mrs. Shirley Cannard.)

Q. Was he lying quietly?

A. Well, he was just complaining of his leg and every once in a while he would groan with pain.

Q. In his back?

A. In his back and leg both. He said it was just like a thousand needles sticking in it.

Q. You lifted the blanket to look at the leg?

A. His leg wasn't covered. They put the blanket over his shoulder because they didn't want to get anything in his leg. [18]

Q. So the blanket was just over his——

A. Over his shoulders and about down to his knee.

Q. You were careful and had been careful to see that nothing touched his injured leg?

A. We didn't take anything away from his leg; left it just as it was. It was starting to rain, so we covered up everything but his leg, because we did not have an umbrella at the time.

Q. You don't know whether he was actually lying partially on the sidewalk before?

A. I don't know because I wasn't there when it happened.

Mr. Harr: That is all.

(Witness excused.) [19]

MRS. FLORENCE MORIN

produced as a witness in behalf of Plaintiff, and being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. John D. Ryan:

Q. You are the wife of Amos Morin, the plaintiff in this case? A. Yes.

Q. Where do you live?

A. 4640 Northeast 30.

Q. Is that where you were living on June 10, 1952? A. Yes.

Q. Were you present at your home on June 10, 1952, when your husband suffered a fall from a ladder?

A. No, I was at work when he fell, and my daughter Shirley called me at work and told me my husband had been injured, and I asked her how severely and she said, "I think his leg is broken." She didn't want to upset me. She said, "I think you should come home right away."

Q. You were working at the airport at that time?

A. Yes, the Portland International Airport.

Q. Did you come immediately to your home?

A. Yes.

Q. Have you some idea what time it was when she called?

A. It seems to me it was 12:30, between 12:30 and 1:00 o'clock. [20]

Q. How long did it take you to get from the airport to your home?

(Testimony of Mrs. Florence Morin.)

A. I don't believe it took me more than ten minutes, twelve at the most.

Q. You were driving your own car?

A. Yes.

Q. When you arrived at your house, would you tell us where your husband was?

A. Yes. He was lying across the sidewalk. His trousers was on the sidewalk; his feet were lying on the grass, with his head in the flower bed near the house.

Q. Where was the lower part of his leg, between the knee and foot? A. Just on the grass.

Q. That is, his left leg? A. Yes.

Q. As well as his right leg? A. Yes.

Q. Go on and describe what you saw.

A. When I drove up, the ambulance had just arrived and the attendants were standing there by him. I knelt down and talked to him just a minute and he was in quite a bit of pain. He said his leg was just throbbing and he was hurt quite badly. It took three of the men to lift him onto the stretcher. I didn't actually see the bone of his leg, but I could see the [21] ankle and foot and it looked crooked to me, and I could tell by that it was definitely broken because it was laying at an off-angle with reference to his body.

Q. Did your husband complain of his back?

A. A little, but the children had told me the doctor said to be careful in moving him, that his back might be injured.

Q. Was he conscious and able to talk to you?

(Testimony of Mrs. Florence Morin.)

A. Yes.

Q. Rationally? A. Yes.

Q. Have you some idea of when the ambulance left with him for the hospital, what time?

A. I can't give you a definite time. It seems it was around 1:00 o'clock.

Q. Did you accompany your husband to the hospital in the ambulance? A. Yes.

Q. Was he covered in the ambulance?

A. I don't remember. I believe he was. Yes, I believe they had a blanket over him.

Q. Did you arrive with your husband at the Physicians and Surgeons Hospital?

A. Yes.

Q. Would you tell what took place then?

A. They took him into the emergency room and they had me [22] out in the hall, and I heard them say, "Mr. Morin, we are going to have to cut your trousers off," and he said, "I don't care; I don't care, my leg is just hurting so bad." Then I didn't hear any more. They closed the door there and I just waited. I waited until away in the afternoon, when either a doctor or an intern came to me and said, "Mrs. Morin, Mr. Morin's back has been fractured and he has an open fracture in his leg. You may go in to see him now." That was in the afternoon.

Q. Do you know who that doctor or intern was who gave you that information?

A. No, I wouldn't know him.

Q. Did you then go into your husband's room?

(Testimony of Mrs. Florence Morin.)

A. Yes.

Q. Was he in a room or ward?

A. He was in a ward.

Q. What did you observe when you went into the room or ward where your husband was?

A. They had the leg lying on a pillow; it was just resting on a pillow, just light—there was no traction. It seemed to me there was just padding or a bandage laid over his leg; it wasn't bound up. He wanted his foot out because he couldn't rest with his foot covered, so I moved the sheet off his foot, so I could see some sort of a bandage just wrapped over it; it looked like something lying there over his leg, on a pillow. [23]

Q. You did not lift or touch the bandage, did you? A. No.

Q. Was any doctor or nurse in attendance when you went in there? A. No.

Q. Was your husband at that time able to talk with you?

A. Well, he talked with me. He was talking and he was awake but every now and then he would repeat the same thing over and I wouldn't know whether he was rational or whether he wasn't but he would repeat the same thing over again and again, every now and then he would.

Q. This time you are describing when you saw your husband was in the later afternoon of June 10, 1952? A. Right.

Q. Did any other representative of the hospital or the U. S. Public Health Service talk with you?

(Testimony of Mrs. Florence Morin.)

A. Any doctor?

Q. Yes.

A. No. I came back in the evening and stayed with him as long as they would allow us to visit.

Q. On June 10th, did anybody talk or discuss with you the question of his treatment?

A. No, not on June 10th.

Q. Did anyone discuss personally with you the question of his treatment on June 11th? [24]

A. On June 11th, when I went to see him—I worked until 2:00 and I got to the hospital about 2:30, when I went to see him. I believe it was a nurse who told me Mr. Morin was to be taken to Seattle to the hospital there, and I said, "No, I don't want that." I was quite upset about it because under the circumstances I thought he should be taken care of there, the fracture, anyway, of his leg, and when I got home I called Dr. Craig at his office and I asked him why they were sending Mr. Morin to Seattle, and he said, "We are not financially able here to keep any long-term patients. Mr. Morin will be a long-term patient and we send all these long-term patients up to Seattle."

I said, "What will they do to Mr. Morin in Seattle"? And he said—he kind of half-laughed about it and he said, "He won't be back to work for six months." I said, "That is not what I am asking you. I am asking what they will do to Mr. Morin," and I said, "First, I think that leg should be set." He said, "Sometimes it is eight days or more before

(Testimony of Mrs. Florence Morin.)

they set a leg," and I said, "What do you think that they will do for him up there"?

That is what I was trying to get at, what they would do for him there; when he went to work was not of concern, but, rather, what could be done for him.

Q. Did he say what he had done for him?

A. No, he didn't say he had done anything, or what. [25]

Q. Did he say anything to you when you told him he was a veteran and able to go to the Veterans Administration Hospital?

A. No, he said, "We send our patients up north. When they come in here in this hospital and they are long-term patients, we send them to Seattle."

Q. Did he discuss with you the treatment of Mr. Morin under the Blue Cross? A. No.

Q. You did tell him Amos was under the Blue Cross? A. Yes.

Q. Is that the extent of your conversation, approximately, with Dr. Craig? A. Yes.

Q. Was this in person or by telephone?

A. It was by telephone.

Q. And this was on June 11th?

A. June 11th.

Q. How did you know to call Dr. Craig?

A. They told me Dr. Craig had said he was going to be sent to Seattle. The nurse told me that, so, naturally, I knew Dr. Craig had been in attendance on him and I naturally called him first to talk to him to see why he was being sent to Seattle.

(Testimony of Mrs. Florence Morin.)

Q. Did you see your husband again after June 11th in Portland? [26]

A. I saw him on June 11th in the afternoon and again at night, during visiting hours at night.

Q. What was his condition when you saw him in the afternoon?

A. Well, he seemed sort of drowsy. I asked him if he knew he was going to Seattle, and then he seemed to know it and——

Q. Did you observe his leg in the afternoon on June 11th?

A. It was just—it looked just the same to me; just lying on a pillow.

Q. Did you observe bandages or anything?

A. It still looked just the same. It looked like—didn't look like there had been any change there at all, because I was looking for traction or something to be done.

Q. Any cast on the leg? A. No, no cast.

Q. On the evening of June 11th could you give us some idea of your husband's condition?

A. Well, he was just about like he had been in the afternoon. He was sort of drowsy and groggy. He wasn't saying a whole lot. It seemed like every time he would move or say anything he would complain that he was hurting.

Q. At any time between the 10th and 11th or until your husband was taken out of the Physicians and Surgeons Hospital on the 12th, did any member or representative of the U. S. Public Health Service contact you and ask what disposition you

(Testimony of Mrs. Florence Morin.)

wanted [27] to have made of your husband's treatment, other than Dr. Craig's conversation?

A. No.

Q. Did you see any doctor in attendance upon your husband at any time that you visited the hospital?

A. There was a doctor—I think it was a doctor—in the room. He was working on another patient across from Mr. Morin when I was talking to Mr. Morin about going to Seattle. I was trying to find out if he knew he was going.

This doctor said, "Oh, yes, he knows he is going to Seattle." I don't know who the doctor was. I didn't pay much attention to just who it was. I was more concerned for Mr. Morin then anyone else.

Q. Did you see your husband on June 12th?

A. No.

Q. When did you next see your husband after June 11th? A. June 14th.

Q. Where was that?

A. In Seattle, in the hospital there.

Q. Had you been in the Seattle hospital prior to June 14? A. Had I been there prior to that?

Q. Yes. A. Yes.

Q. When did you go to Seattle?

A. We went up in the morning and it seems like we got in [28] about 11:00. I am not just positive of the time, but we drove up. My oldest daughter and I drove up in the morning and we visited him there before noon.

(Testimony of Mrs. Florence Morin.)

Q. That was on June——

A. ——14th.

Q. June 14th?

A. Saturday, June 14th.

Q. You went out to the U. S. Marine Hospital?

A. Yes.

Q. Were you able to see your husband immediately? A. Yes, they let us in to see him.

Q. Where was he?

A. He was in a room by himself and there was an orderly there, and he was taking care of Mr. Morin. He was sitting by his bed, because he was rolling and rising in pain. He had a body cast on and a full leg cast.

This orderly said, "What did they do to Mr. Morin? He is almost dehydrated. As long as you folks are here, will you please give him all the liquids he can take and each time he takes it write down the amount and what he takes on this sheet of paper," and he left a sheet of paper and a pencil there.

So we waited, my daughter and I. We left only long enough to have a bite to eat and we came back in the afternoon and stayed with Mr. Morin, doing the same thing, [29] but when I went out to get lunch a nurse stopped me in the hall and she said, "What in the world happened to that man? We don't have any record of it. What happened? How did he get hurt"?

She said, "He came in here and we treated him

(Testimony of Mrs. Florence Morin.)

just like an emergency. It was a matter of taking him right to the operating room and setting the leg."

She said, "He was sent from down there with the bone sticking through the flesh of his leg," and I said, "I didn't know that." When I saw him, they had already put on the body cast.

Q. Did you see your husband's arms exposed?

A. Yes. Both arms were bruised like they may have been tied down. Both arms along here were bruised. The back of his head was all scraped like it had been rubbing against something here.

Q. Did you observe these bruises previously when you saw him at the time of the accident or at the Physicians and Surgeons Hospital?

A. No.

Q. How about the scraping on the back of his head? A. No.

Q. Your husband is bald, isn't he?

A. Yes. His head was scratched. There was a red scratch right down the middle of his head. [30]

Q. Did any of the physicians in attendance at the hospital talk to you about the treatment of Mr. Morin other than the nurse and the orderly that you have testified about? A. There in Seattle?

Q. Yes.

A. That is all that talked to me at Seattle.

Q. What was the condition of your husband when you arrived? Was he rational or not?

A. No; Mr. Morin, I don't believe, knew us. He was twisting and turning; he was in quite a bit of pain and agony. I don't believe he knew us.

(Testimony of Mrs. Florence Morin.)

Q. Had your husband been an active man previous to this injury?

A. Oh, yes; very much so.

Q. Did you folks engage in any social life, the usual social life?

A. Oh, yes; we danced and went swimming, and played some tennis, and he played a lot of ball with the boys.

Q. Were you accustomed to dance socially?

A. Yes.

Q. About how frequently would that be?

A. Probably once a month we would go dancing, maybe more often.

Q. Has he been able to participate in dancing since then?

A. No, he has not. He can't even work in the garden. [31]

Q. Did he enjoy dancing before? A. Yes.

Q. From your observation, anyway?

A. Yes, very much.

Q. Was your husband a swimmer? Did he enjoy swimming?

A. Yes, he was quite a good swimmer.

Q. Was he out with you frequently or infrequently during the summer?

A. During the summer we went maybe once a week swimming.

Q. Has he been able to do that, according to your observation, since he returned?

A. No, he has not been swimming at all.

Q. How many children have you people?

(Testimony of Mrs. Florence Morin.)

A. We have six.

Q. How many of them are living at home now?

A. Three.

Q. How many were living with you at home at the time of the accident? A. Four.

Q. Did Shirley leave soon after that?

A. Yes, Shirley was married later.

Q. What are the ages of the three children that are now at home? A. 14, 16 and 18.

Q. Did your husband help around the house, or was he one [32] of those fellows who is not much of a handyman?

A. He was a great helper, of great help. It seemed like he couldn't sit still in the evening; he had to have something to do, some kind of work or hobby. He would work in his garden.

Q. What kind of a garden was it? A vegetable garden? A. A vegetable garden.

Q. Did he aid you in doing the household chores?

A. Oh, yes; if I wasn't well, and if we wanted to go somewhere he always helped me in the work.

Q. You said you were employed at the airport in the restaurant. Are you working now?

A. No, not now.

Q. Were you working regularly at the time of his injury? A. Yes.

Q. Did you continue to work after that?

A. Yes.

Q. When did you cease working?

A. February 20 of this year, 1954.

(Testimony of Mrs. Florence Morin.)

Q. Is he able to be of any assistance around the house now?

A. Not too much, no. It hurts him if he has to walk, so he takes it pretty easy now.

Q. Is he able to engage in any of his former activities? A. No.

Q. Have you some idea when he got to the hospital, the [33] Physicians and Surgeons Hospital?

(Recess.)

(Question read.)

Q. (By Mr. John D. Ryan): I asked you if you had some idea what time your husband got to the Physicians and Surgeons Hospital in Portland, Oregon, on June 10, 1952?

A. As near as I can place it, it was shortly after 1:00, around 1:00 or shortly after.

Q. Do you know of your own personal knowledge what time he left the Physicians and Surgeons Hospital?

A. I called up over there and they said he had left in the late morning.

Q. On which date, please?

A. The morning of the 12th.

Q. Of June?

A. Yes. I thought probably if he hadn't gone I could see him when I got off work, but they said he had left that morning.

Q. You have testified you saw your husband on June 14th in Seattle at the Marine Hospital?

A. That is right.

(Testimony of Mrs. Florence Morin.)

Q. At the time you saw him he was in bed?

A. Yes, and he had on a leg cast and a body cast.

Q. He had a leg cast and a body cast? [34]

A. Right.

Q. You observed the bruises on his arm and on the top of his head, abrasions on the top of his head? A. Yes.

Q. Were you able to stay at the hospital with your husband at that time?

A. I stayed until Monday. I was with him as much as they would let me stay during the three days.

Q. The 14th would be Saturday?

A. The 14th, 15th and 16th.

Q. What was the condition of your husband during that time that you saw him?

A. The first day he didn't seem to be rational. Sunday, I think, he recognized us a little, and then Monday, I believe, he knew that we were there and who we were.

Q. When did you next see your husband?

A. The following week end on Saturday. That would be the 21st.

Q. Was he still in the same cast?

A. Yes, still had the same cast.

Q. The following week end would be June 21st?

A. Right.

Q. Had he become rational?

A. Yes, he knew us then.

Q. What was his condition? [35]

(Testimony of Mrs. Florence Morin.)

A. Well, he was in quite a lot of pain, and he said he didn't feel the bone was set. He said it felt like he could feel the bone scraping in the cast, grating in the cast.

Q. On June 14th did he complain about his leg?

A. Oh, yes. He rolled in bed, in pain; his back was hurting; his leg was hurting him.

Q. And on the 21st the same thing again?

A. Yes, he was still in quite a lot of pain with his leg.

Q. How long were you able to stay with him on the 21st?

A. I visited him in the evening of the 21st. I got up there in time to visit him in the evening after dinner, and then on Sunday during visiting hours, and then I left again for Portland.

Q. Did you return again to see him after that?

A. Yes, each week end I drove up there.

Q. The next week end would be approximately the 29th of June, if the 21st was a week end?

A. Yes.

Q. Had there been any change of the cast at that time?

A. Well, I can't remember as to just the date, no. I know he was changed into a ward with a number of other patients and I can't remember for sure whether he had on this cast or what they had done for him. I know he was still in a body cast. They had changed his body cast and put one on [36] which was tighter than the one they previously had, but the date I can't tell exactly.

(Testimony of Mrs. Florence Morin.)

Q. Did he have any further surgery at the Seattle Hospital?

A. At Seattle they put a metal plate of some sort on the bone.

Q. Was that approximately July 15th that that took place? A. I can't remember the date.

Q. Were you there at the time this surgery took place at the hospital? A. No.

Q. Up to the time they did that, had the cast been opened?

A. Yes; there had been a window cut in it. It had been bleeding quite profusely.

Q. Was this prior to the operation that you are talking about? A. I believe it was.

Q. Prior to the operation on the 11th or the 13th did any member of the staff, any doctor, discuss Mr. Morin's case with you?

A. No, they did not.

Q. Did—it is your recollection that a window had been cut in the cast after that?

A. Yes. I am pretty sure it was. I am not positive, but I am pretty sure it was.

Q. After the operation in July, the 11th or 13th, when did [37] you next see Mr. Morin?

A. I saw him each week end; each Saturday and Sunday I saw him up until the time he came home.

Q. After that operation was the cast on his leg?

A. In Seattle, you mean, after his operation?

Q. Yes. I am talking about the operation of July 13th. A. Yes, they had a cast on his leg.

Q. From the time the operation took place until

(Testimony of Mrs. Florence Morin.)

Mr. Morin left the hospital did you observe a window in the cast at any time?

A. Yes, it seems he couldn't stand the cast very long before they would have to cut a window in there to relieve the pressure. There seemed to be pressure on the leg, and it would commence to pain him badly, and they would cut a window in the cast.

Q. Did you have opportunity or reason to see the open wound at any time?

A. No; not at Seattle.

Q. Was any treatment being given to the open wound in your presence?

A. Not to my knowledge.

Q. It is my understanding that Mr. Morin left the hospital on or about the 13th of August?

A. Yes.

Q. 1952? [38] A. That is right.

Q. Were you at the hospital prior to the time Mr. Morin left?

A. No. I came up and as soon as we could get the papers together for his release we left shortly. I was just there a little while.

Q. Did you at the time this was being done have reason to talk with any of the hospital staff?

A. No.

Q. Did you take Mr. Morin from the hospital to Portland, Oregon? A. Yes.

Q. How did you transport him?

A. In the car.

Q. At the time you transported him, would you describe the condition of the cast, if you can?

(Testimony of Mrs. Florence Morin.)

A. Well, it was just a cast. That is all I could tell you.

Q. Was there a window cut in the cast?

A. I believe there was a window in the cast.

Q. Do you recall whether the cast was sealed or whether it was open?

A. I believe it was sealed.

Q. When you arrived in Portland—first of all, when did you arrive in Portland after leaving on the 13th of August from Seattle? [39]

A. I don't believe I could tell you the exact time. It was early afternoon.

Q. Do you know what time you left Seattle?

A. No, sir; I don't.

Q. Where did you take Mr. Morin when you reached Portland?

A. I brought him directly home and put him to bed.

Q. Put him to bed? A. Yes.

Q. Did you contact any doctor?

A. Yes, I talked to Dr. Thorup and he saw him on the 14th.

Q. That would be the following morning?

A. Yes, the following day, the following afternoon.

Q. Did Dr. Thorup give him any treatment, to your observation?

A. He gave him penicillin. I think he saw to it that he had a shot of penicillin every day.

Q. Did Mr. Morin leave the house for treatment after the 14th?

(Testimony of Mrs. Florence Morin.)

A. No; the nurse came to the home and gave him shots of penicillin.

Q. Did you ever take him to Dr. Thorup's office?

A. Not right then, I don't believe, no.

Q. Did he go to Dr. Thorup's office between August 13th and August 24th?

A. I don't remember. I believe he did. [40]

Q. Did Mr. Morin go to any other hospital after leaving the Marine Hospital at Seattle?

A. Yes; he went to the Providence Hospital.

Q. How soon after he got home from Seattle was that?

A. I couldn't give you the date, but it was not too long afterwards. Dr. Thorup called in Dr. Cherry to work on his leg. I believe they set it at one time and then another time I believe they removed the metal plate from his leg, also.

Mr. John D. Ryan: I have no further questions.

Cross-Examination

By Mr. Harr:

Q. Did Mr. Morin tell you on the day he arrived at Seattle that he took the cast off himself?

A. The cast on his leg?

Q. Yes. He didn't tell you that? A. No.

Q. Did he tell you that he fell from the stretcher onto the floor? A. Yes, I knew he fell.

Q. He told you about that? A. Yes.

Q. That was shortly before you brought him home, I believe? A. Yes. [41]

(Testimony of Mrs. Florence Morin.)

Q. Did you talk to Dr. Craig or any of the other doctors here in Portland?

A. I called Dr. Craig on the phone.

Q. In talking to him you told him he was a veteran and was entitled to treatment at the Veterans Administration Hospital?

A. I told him that he was a veteran and that we had Blue Cross.

Q. What was your reason for telling him that?

A. Because I didn't want them to take him to Seattle where I couldn't see him very often, because I was working and I knew then I would have to continue to work and with him in Seattle it would be difficult for me to go up there to see him. I wanted him here—I didn't tell him I wanted him here, but that is the reason I mentioned the Blue Cross and his being a veteran, because I would much prefer that he stay in Portland where I could visit him every day.

Q. Up to that time did you have a feeling you would have preferred to have had him under the Blue Cross or under the Veterans Administration care?

A. I thought I would still have him here, that he would be here in Portland. That would be where I could visit him.

Q. You misunderstand the question. Up to the time you got word, up to the time you found out they were going to transfer him to Seattle, up to that time had you indicated any desire [42] of him being under the Blue Cross?

(Testimony of Mrs. Florence Morin.)

A. No, I didn't.

Q. In fact, you signed a statement, didn't you, where you accepted, on behalf of your husband, treatment by the U. S. Public Health Service?

A. Treatment here in the hospital.

Q. You remember signing that?

A. Yes. I understand that because they had to have his name and address, and so forth.

Q. Up to that time you were satisfied with the fact that he would be treated by the U. S. Public Health Service? A. Yes, here in Portland.

Q. Did you do anything about that? This was on the afternoon of the 11th, you said?

A. Yes. Then when I went to visit him in the afternoon I found he was being transferred to Seattle and that upset me quite badly. I didn't like the idea of him being so far away. I called Dr. Craig when I arrived home, called him at his office and talked to him there.

Q. What time was that in the afternoon?

A. After visiting hours at the hospital, after we were there. I don't know exactly. It was in the afternoon, as soon as I arrived home.

Q. What time would you arrive home, ordinarily?

A. I don't think the visiting hours were over an hour or [43] an hour and a half, but I am sure it was before 4:00 o'clock that I called him.

Q. Did you talk with your family doctor, Dr. Thorup? He was your family doctor?

A. Yes.

(Testimony of Mrs. Florence Morin.)

Q. Did you tell him you did not want your husband to go to Seattle?

A. No, I didn't talk to Dr. Thorup about the trip to Seattle. I just talked to Dr. Craig.

Q. Did you tell anybody else you did not want him to go to Seattle?

A. Only the nurse. I told her I was very unhappy about his going there.

Q. Other than what the nurse told you when you were in Seattle, which I believe you said was June 11th, is that right? A. No, June 14th.

Q. The 14th? A. Yes.

Q. Other than what the nurse told you to the effect, "Well, we don't know anything about what had happened to him," other than that you did not talk to any of the doctors to find out if they had received any history that accompanied him on the ambulance?

A. No; just the nurse is all I talked to about that. [44]

Q. When you saw your husband in the Physicians and Surgeons Hospital at Portland, you just lifted the sheet and it seemed to you like there was a bandage across his leg?

A. Yes. There was something lying across his leg. I uncovered his foot and ankle.

Q. Do you know whether or not the wound was splinted, splinted or bandaged?

A. No, there didn't seem to be any bandage around it; just seemed to be one laid over it.

(Testimony of Mrs. Florence Morin.)

Q. Are you able to say definitely that there was no bandage on the leg?

A. Not to my suspicion there wasn't.

Q. You are giving us your impression; that is what you are giving us now?

A. I couldn't say positively that there was a bandage around the leg or that there wasn't. I know that there was just a covering over it.

Q. You have not examined the hospital records yourself, have you? A. No.

Q. You have talked to your attorneys frequently about the case and have talked to them recently?

A. Not too frequently.

Q. Of course, your attorneys have examined the records both of the Physicians and Surgeons Hospital and of the [45] hospital in Seattle. Did they tell you that the records show that your husband while he was there for nearly a month complained almost entirely of pain in his back and not in his leg?

A. No. When I was with him, it was his leg that he complained of.

Mr. John D. Ryan: I do not think that is proper examination.

The Court: Go ahead.

Q. (By Mr. Harr): He came back from Seattle at his own request, did he not? A. Yes.

Q. And against the advice of the doctors there, is that not true? A. Yes, that is true.

Q. They told him that if he were to leave the

(Testimony of Mrs. Florence Morin.)

hospital it would be at his own risk, that they would not be liable for anything that might happen?

A. I don't know that they told him that, no.

Q. You did not see the doctor?

A. That is right.

Q. He came to Portland and of course went immediately under the care of your family doctor, Dr. Thorup? A. Yes.

Q. Did you then see the wound itself? [46]

A. No, not right then.

Q. Was the cast on at the time he went to the hospital, Providence Hospital, the latter part of August? A. Yes.

Q. That is the time that Dr. Cherry was called in and they did some manipulation of the bone?

A. Right.

Q. Then there was subsequently an open operation by Dr. Cherry in the following January, January of 1953? A. Yes.

Q. But before that, in December, he went to work?

A. Yes, he went to work with the cast on his leg, but he couldn't stay.

Q. He went to work with the blessing of his own doctor?

A. He worked just a short time; they gave him a watchman's job, just a watchman's job.

Q. Did you see the wound itself at any time between August and the time he went to work?

A. No, I don't think I did.

Q. Was it in a cast all the time?

(Testimony of Mrs. Florence Morin.)

A. They had it in a cast. They would remove one cast and put on another.

Q. Did they window the cast——

A. They windowed the cast but not right away. When they put on a new cast, he would wear it for a while before it was [47] windowed.

Mr. Harr: I have no further questions.

Q. (By Mr. John D. Ryan): When you talked to Dr. Craig, you relied on what he told you as a doctor, didn't you? A. Yes, sir; I did.

Mr. John D. Ryan: Thank you.

(Witness excused.)

Mr. John D. Ryan: I will call Dr. C. O. Schneider as an adverse witness.

Mr. Luckey: There is no showing that the witness is adverse.

The Court: I will make my own appraisal of that. [48]

DR. CONSTANTINE OTTO SCHNEIDER produced as a witness on behalf of Plaintiff, and being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. John D. Ryan:

Q. You are Dr. Constantine Otto Schneider?

A. Right.

Q. Are you a medical doctor? A. Yes.

Q. Will you state for our information your edu-

(Testimony of Dr. Constantine Otto Schneider.)
cation, your professional education and qualifications?

A. I graduated from the University of Oregon in 1950. During my senior year, in addition to my last year of schooling, I took a year's internship at the Physicians and Surgeons Hospital. Following graduation, I went to the Ancker Hospital in St. Paul for a general rotating internship and, after leaving St. Paul in June, 1951, I returned to Portland for a year of general surgery, general surgical and medical residency at the Physicians and Surgeons Hospital.

Q. I have some difficulty hearing you. Was your last statement to the effect that you had a residency at the Physicians and Surgeons in 1951 and 1952?

A. That is correct, sir.

Q. What did you do thereafter?

A. After my residency? [49]

Q. After your residency.

A. In July of 1952 I started the general practice of medicine in Portland.

Q. Are you now practicing?

A. I am now engaged in general practice.

Q. On June 10, 1952, what was your occupation?

A. I was a resident in the Physicians and Surgeons Hospital.

Q. What did your duties consist of at that time as a resident of the Physicians and Surgeons Hospital in Portland, Oregon?

A. This residency was primarily directed to surgical training and medical training. Our primary

(Testimony of Dr. Constantine Otto Schneider.)
duties were to assist the surgeons in surgery and to assist the other physicians on the floor in the care of medical patients, particularly in the care of medical patients and to help take care of emergencies as they might arise.

Q. How long had you been a resident on June 10, 1952?

A. I believe, if I remember correctly, my residency started here about the 15th of July, approximately the 15th of July in 1951.

Q. 1951? A. 1951.

Q. Your experience previous to the 15th of July, 1951, was as an intern?

A. Had been as an intern and—— [50]

Q. Where was your internship, here or in Minnesota?

A. At the Ancker Hospital in St. Paul, Minnesota.

Q. On June 10, 1952, did you treat Amos Morin?

A. As I remember, I believe I did do some kind of initial treatment for Mr. Morin.

Q. Do you recall under whose name Mr. Morin was admitted to the hospital?

A. As I remember, he was admitted under Dr. Lee Craig.

Q. Who is Dr. Lee Craig?

A. At that time he was a member of the U. S. Public Health Service in Portland.

Q. At this time, Doctor, would you inform us in detail of your experience in the treating of compound fractures of the lower part of either extrem-

(Testimony of Dr. Constantine Otto Schneider.)

ity, the left or right leg, at that time, June 10, 1952?

A. Prior to the time that I saw this case and for the balance of June, my experience was primarily work undertaken under the supervision of other physicians. I had seen perhaps one or two or three cases where I had observed as they were treated, or helped in treatment of them.

Q. Could you name the very first experience you had and tell what that was?

A. I couldn't state specifically.

Q. In other words, where you had your first experience with a compound fracture. [51]

A. My first experience was as an intern at St. Paul, in the Ancker Hospital, in emergency care, primarily emergency care before the patient was admitted to the hospital.

Q. Were you assisted by anyone at that time?

A. We were assisted by the nurses in that hospital.

Q. That was emergency care? A. Yes.

Q. What did that consist of?

A. Generally an examination and superficial cleansing of the wound, applying splints if necessary, ordering X-rays and possibly writing the initial orders to return the patient to the surgical floor.

Q. That took place in connection with your first experience?

A. As I recall it, that is what our duties were at that time.

(Testimony of Dr. Constantine Otto Schneider.)

Q. Could you recall possibly the next experience of that type that you had?

A. It would be impossible to say exactly. I think it was while I was at Ancker that I had seen, not fractures of this exact type, but I had seen other compound fractures and had taken part in the care of them.

Q. Had you had any other experience other than the one you have told us about prior to June 10, 1952?

A. No, I couldn't specifically say the exact location of [52] the fracture that I helped with, but I can remember one more case. I can't remember whether it was in the lower tibia or the upper tibia.

Q. Did you have one of the upper tibia?

A. I say I cannot remember in that one specific case whether it was the lower or the upper or middle.

Q. That is, the one you described?

A. That I previously described, yes.

Q. Can you recall any specific instance of treating either the upper or lower tibia or any part of the tibia, for the compound fracture?

A. Not specifically. I perhaps might have assisted on some.

Q. That you actually treated and assumed complete treatment of it at the time the patient was brought in? If you had actually treated it and assumed complete treatment, you would recall it, wouldn't you? A. I believe I would.

Q. I asked you about treating, actually being the

(Testimony of Dr. Constantine Otto Schneider.)

treating physician of this type of injury, prior to June 10, 1952. Would you give us in detail the number of times and occasions upon which you observed the treatment of this type of an injury?

Mr. Harr: For the record, I would like to have it clarified as to just what Counsel means by "this type of injury." [53] Does he mean a compound fracture of the lower tibia, or does he mean a compound fracture——

Mr. John D. Ryan: My question is directed towards compound fractures of the tibia, either the left or right leg. If you care to distinguish between the upper part and the lower part, I am not certain what the definition would be. If you care to do that, to make that distinction, please do so in your answer.

A. I can best answer that by saying in the initial care, the emergency phase, that perhaps prior to this one that I had any actual integral part in treating, perhaps one or two cases, one that I was specifically involved with or that I took part in, and perhaps one more while I was on the emergency service at Ancker Hospital.

Q. You mean the ones you have already described and then this one?

A. Perhaps one more.

Q. By "integral part in the treatment," what do you mean by that?

A. Where I had actually assisted or taken part in the initial emergency care.

Q. What do you deem to be initial emergency

(Testimony of Dr. Constantine Otto Schneider.)

care? What was the initial emergency care in those cases?

A. Treating the patient for shock, trying to immobilize the leg, superficially cleansing the wound, ordering X-rays, [54] placing the patient in a hospital bed, placing the patient where he can be taken care of by whoever is the responsible physician.

Q. Is that the extent of your experience, as you recall it now? A. I believe so.

Q. As of June 10, 1952? A. Yes.

Q. I am not speaking of subsequently.

A. Except I think perhaps one or two cases prior to that time.

Q. Had you had experience in the treatment of any other compound fractures?

A. In the emergency service at Ancker Hospital we got a good deal of them, and also in the surgical service, but I couldn't mention the number of cases specifically. I couldn't say whether it was six or ten or five or what.

Q. Would that be treatment in the emergency room and then sending them up to the surgical floor?

A. It depends on the service. If we are on emergency service, we do the emergency care in the emergency room and then we send the patient to whatever service his treatment required. If we happened to be on the service receiving the patient, we immediately took over the care of that patient on the floor. [55]

Q. As far as the actual treatment and the loca-

(Testimony of Dr. Constantine Otto Schneider.)

tion of these wounds, it was confined to the emergency room?

A. The initial care, yes; the final definitive treatment was always done in the surgical service.

Q. What was your duty on June 10, 1952, at the Physicians and Surgeons Hospital?

A. The duties were, as I outlined before, and apparently, since I had initially examined Mr. Morin, I imagine that I was on the floor at the time and doing emergency work in the emergency surgery there.

Q. You say you imagine. Do you actually recall what took place?

A. I remember being in there at the time Mr. Morin came in or being called.

Q. Would you describe what took place when Mr. Morin came in there on June 10, 1952, at the Physicians and Surgeons Hospital in Portland, Oregon?

A. At the time he was brought in and I was called to the emergency room, I remember primarily the fact that he was having extreme pain. At that time, which was my major contact with this patient, his pain, his major pain, was pain in the back, but he was running a somewhat steady pulse, as I remember. I did the usual check for the possibility of shock—blood pressure, pulse and respiration—and, as I remember, I ordered certain specific medication for pain [56] and for infection.

Q. Do you know what this specific medication consisted of?

(Testimony of Dr. Constantine Otto Schneider.)

A. I believe I ordered morphine for pain and penicillin for the possibility of infection.

Q. You say you treated him for shock. Was he in shock?

A. He was in what I would term incipient shock.

Q. Were you assisted by anyone at this time?

A. I was assisted by a nurse.

Q. What did you then do to the patient?

A. As soon as we had him on the table and had given the medication I described and had done the blood pressure, pulse and respiration and had checked his wound superficially, I tried to determine the extent of his injuries.

On examination we found a couple of small lacerations and a large abrasion in the left leg with palpable crepitus. As I remember, the bone was visible through the wound or wounds.

Q. What do you mean by "palpable crepitus"?

A. By generally feeling, you could feel the scraping, which is typical in any fracture.

We examined him somewhat in reference to his back, but his pain was so severe that we did not want to manipulate it too much at that time.

Q. What did you then do?

A. As soon as we felt he had stabilized somewhat—I [57] would say within 30 or 45 minutes—I ordered—first, after we had cleansed the wound, we examined it to see if there was any gross evidence of any bleeding, and, as I remember it, we washed it with an antiseptic and cleansed it until fairly clean and then applied a dressing and, as I remem-

(Testimony of Dr. Constantine Otto Schneider.)

ber, it was splinted, and the patient was then sent to X-ray within perhaps a half hour or forty-five minutes, for a film of the leg or back.

Q. You say you think it was splinted. What type of splint was used?

A. As I remember, I used a board splint.

Q. What type?

A. There are various types. I think the type of splint, if I remember correctly, that was used was called a Yucca board.

Q. What was the length of the board splint?

A. I couldn't recall exactly offhand.

Q. From your familiarity with splints in general, was it of uniform size? Are they all of uniform size?

A. They can be from two inches long for a finger to six feet long for the back.

Q. Was this one six inches or six feet long?

A. I would say that this splint—I would have to measure—would be between 24 and 36 inches long.

Q. Where did the splint extend? [58]

A. As I remember, it extended to the level of the ankle and to slightly above the knee.

Q. Are you certain you used a splint?

A. I feel positive that I did splint the leg. Whether I splinted it before we had the film or afterwards I couldn't exactly say, but I am positive we splinted the leg.

Q. You are familiar with the records of the Physicians and Surgeons Hospital with regard to this case, is that correct?

(Testimony of Dr. Constantine Otto Schneider.)

A. I have examined them.

Q. You have examined them? A. Yes.

Q. You have been handed Plaintiff's Exhibit No. 1. Are you able to identify those records, from your previous observation of them?

A. I would say that these would constitute probably the entire record. The one you showed me before was a photostat.

Q. The photostatic copy is here, if you would prefer to look at that.

A. No, this is sufficient.

Q. Does that record show what type of splint you used? A. I don't believe it does.

Q. Does the record show you used any splint?

A. I don't believe it does.

Q. Would you read the statement of what was done, in the [59] record that you have here?

A. There is no statement in the record of exactly what was done by me, except as to my initial——

Q. Is there any record there—is that the out-patient record that you have as well?

A. The out-patient record is here, yes.

Q. Do you have before you any record of treatment by you regarding the treatment you have just described? A. Not specifically.

Q. What does it show regarding it?

A. It says here, "Morphine gr. 1/6 for pain at 1:30 p.m.; compression dressing to left lower leg; Abbocillen 800,000; catheterized, specimen to laboratory; admitted to Room 115."

Q. Does the record which you have had an op-

(Testimony of Dr. Constantine Otto Schneider.)
portunity to look at show at any place what you actually did to this patient?

A. Nothing except my initial orders.

Q. That description you have just read, indicating the morphine and bandaging? A. Yes.

Q. Do you know who made that entry?

A. I do not.

Q. Who would normally?

A. The nurse on duty might make it; ordinarily, of course, I myself or the physician—— [60]

Q. Do you customarily make a notation or record of your treatment of a patient as received in the emergency room? A. Ordinarily.

Q. Did you in this instance?

A. Apparently I did not.

Q. You are, therefore, depending exclusively upon your memory as to what took place June 10, 1952, with regard to the treatment?

A. To the best of my recollection.

Q. You have looked through that record and you cannot find in that record any statement of what your treatment was? A. Not specifically.

Q. Is there any statement at all which would indicate what your treatment was?

A. My initial orders.

Q. What are they?

A. After the patient was sent to bed, they are the initial orders that were written, and that is about the extent of my entries.

Q. What is the extent of your recollection, that

(Testimony of Dr. Constantine Otto Schneider.)
you externally cleansed these wounds with a mild saline solution?

A. A sterile saline solution.

Q. You then opened the wound?

A. Yes. [61]

Q. You believe you put a splint on the wound, the nature of which you cannot certainly recall?

A. Not offhand.

Q. The hospital record itself only indicates bandaging, is that correct?

A. It says "compression dressings," which is different than an ordinary bandage.

Q. Compression dressings to the lower left leg?

A. Yes.

Q. Penicillin, 800,000 units. Would you describe the type of compression dressings you put on?

A. A compression dressing consists of dry, sterile dressing applied directly over the wound; then the entire leg is wrapped in what we call compression cotton, which is a heavy, bulky cotton, you might say; the compression cotton is thoroughly wrapped on and then Ace bandages applied to maintain compression of the leg, to prevent bleeding and to prevent swelling.

Q. If you do use a splint in a situation like this, would you normally make a notation of the use of a splint in your description of what was done?

A. Ordinarily.

Q. I notice on the out-patient record—have you that in front of you? [62] A. Yes.

Q. It indicates under the words "insurance

(Testimony of Dr. Constantine Otto Schneider.)

case" the letters "USPH." A. Yes.

Q. You have stated the patient was entered under the name of Dr. Craig. Did you know of your own knowledge whether Dr. Craig was a physician and surgeon?

A. At that time I believe Dr. Craig was a physician of the Public Health Service here in Portland.

Q. Did you notify Dr. Craig of the presence of the patient at the hospital?

A. I believe I did phone him.

Q. When did you telephone him?

A. As I remember it, I telephoned him shortly after I had made my initial examination.

Q. Was that prior to the time you cleansed the wound externally?

A. No, I believe it was after.

Q. To your knowledge, did you notify Dr. Craig what you had done?

A. As I remember it, I told him what we had found on superficial examination and what was suspect; what we had found and what was done, and suggested that we send the patient to X-ray.

Q. What did you tell him you found out? Specifically what did you say? [63]

A. I can't remember my exact words, but I believe I notified him he had a compound fracture of the left lower leg and I believe there was a back injury present.

Q. That there was a back injury?

A. A back injury, yes.

Q. What did Dr. Craig inform you?

(Testimony of Dr. Constantine Otto Schneider.)

A. As I remember, he suggested that we go ahead with the X-rays and contact Dr. Leonard.

Q. In your position as resident you have stated it was your duty to see people in an emergency and give them such emergency treatment as you could. Was it your duty also to notify the doctor in whose name the patient was admitted? A. Oh, yes.

Q. Were there limits to your right to treat a patient?

A. Well, you mean my right to carry on treatment? Well, certainly, my treatment was confined to an emergency. It would be necessary in an emergency to give the same sort of treatment that anyone who sees a man with a fractured leg would be entitled to give.

Q. You deemed this to be an emergency?

A. I deemed that to be an emergency.

Q. You deemed the treatment you gave to be emergency treatment?

A. Well, initial care, emergency care.

Q. When would you say that emergency [64] ceased?

A. I would say, as far as I was concerned, my personal responsibility, perhaps when I phoned Dr. Craig.

Q. That was the end of your responsibility?

A. The emergency was not over, but that was when my initial care ceased.

Q. Dr. Craig had been informed of the patient's condition and your emergency care ceased?

(Testimony of Dr. Constantine Otto Schneider.)

A. I would have continued my care under his direction.

Q. Did you do so in this case?

A. In this case, yes.

Q. What did he direct you to do?

A. As I remember it, at the outset, to start to go ahead and have the X-rays made, admit the patient to the hospital ward and, as I remember it, he told me to call Dr. John Leonard.

Q. Where was Dr. Craig when you called him?

A. As I remember—I couldn't say exactly, but it seems I called him at the office.

Q. Did Dr. Craig come to the hospital on June 10th, to your knowledge?

A. I couldn't answer that.

Q. Can you look at the clinical record that you have? A. Yes.

Q. Would it indicate Dr. Craig did come to your hospital on June 10th? [65]

A. I see no entry on the 10th.

Q. Can you tell from looking at the records when Dr. Craig first appeared as shown by the hospital records?

A. The first entry made directly on the chart is on the 11th, the morning of the 11th.

Q. Can you recall the time when Mr. Morin was brought to the hospital?

A. I recall seeing Mr. Morin, and it was shortly after lunch, as I remember.

Q. Would you use the records there to refresh your recollection?

(Testimony of Dr. Constantine Otto Schneider.)

A. It may have been at 1:15 p.m.

Q. You testified you notified Dr. Craig by telephone as soon as you had completed the emergency treatment? A. I said I believe I did.

Q. How long did this emergency treatment take?

A. I would say 30 to 45 minutes.

Q. The patient was then taken to X-ray?

A. Shortly after that he was taken to X-ray.

Q. Then where was he taken?

A. After that he was admitted to a bed in what was then Room 115.

Q. Did you continue to attend the patient throughout the night of the 10th of June?

A. I believe Dr. Stalder was on call that night, as I [66] remember.

Q. Please refer to the exhibit which you have in your hand. Would you look at the doctor's order sheet, which is one of the sheets of the exhibit?

A. Yes.

Q. You will see "Name: Mr. Amos Morin; Room or Ward No.: 115; Bed: 8; Hospital No.: 97614; Doctor: Craig." A. Yes.

Q. Are those orders marked down as of "6/10/52" orders given by you? A. Yes.

Q. Is that your signature (indicating)?

A. That is mine.

Q. What was the purpose of No. 1, Penicillin?

A. The purpose of the penicillin was to allay possible infection, which is done in any wound of this kind or any other open wound.

(Testimony of Dr. Constantine Otto Schneider.)

Q. As to the remaining five orders, can you inform us as to why you gave those orders?

A. The second order is for morphine sulphate, for pain, given to help allay shock. In this particular case I ordered a complete blood count and, to avoid shock, I ordered that they have blood available. Sedation was indicated and I ordered Sedamyl. I ordered Deprapanex, 4 cc's, intermuscular. That is a gentle bowel stimulant, given to allay ileus. I ordered general diet as tolerated but none until Dr. Leonard [67] gives his OK.

Q. I notice "but none until Dr. Leonard gives OK." In your conversation with Dr. Craig did he ask you to notify Dr. Leonard or did he say he would notify Dr. Leonard?

A. As I remember, I believe that he asked me to call Dr. Leonard.

Q. Did you do so?

A. I believe I talked to him after we sent the patient to X-ray.

Q. Who is Dr. Leonard?

A. Dr. John D. Leonard was or is a surgical consultant to the U. S. Public Health Service in Portland.

Q. What would be his customary duties on June 10th, 1952, as surgical consultant?

A. I am not aware of his exact duties, but I would assume his duties would be to take over on the case if he were asked by the U. S. Public Health Service.

Q. Did you call Dr. Leonard?

(Testimony of Dr. Constantine Otto Schneider.)

A. I believe I did call him that afternoon. I can't remember exactly whether I called him or whether Dr. Craig did.

Q. Does the record of the hospital that you have there show that a call was made to Dr. Leonard?

A. No, it does not.

Q. Do you recall talking to Dr. Leonard? [68]

A. I say I can't recall exactly whether I talked to him or whether Dr. Craig talked to him, but I think I did.

Q. Have you, since that time, asked Dr. Leonard if you called him? A. I have not.

Q. You have under "3"—"Match STAT." You have indicated the cross-matching of blood for possibility of shock. Does the hospital record indicate you had to give plasma or whole blood for shock?

A. I believe none was given.

Q. That was never given? A. No.

Q. When was the next time you saw the patient after giving these orders which are on the doctor's order sheet?

A. I saw him several times during the day, and Dr. Stalder did, too. We saw him again at 3:00 o'clock.

Q. That afternoon?

A. Yes. Dr. Stalder saw him again at 5:45.

Q. You are reading from the orders of the 11th?

A. No, I am looking in the nurse's notes.

Q. The bedside notes regarding Amos Morin?

A. Yes.

Q. For the month of June, Dr. Craig?

(Testimony of Dr. Constantine Otto Schneider.)

A. Yes.

Q. Had there been any essential change in the condition of [69] the patient at any of these visits?

A. Initially, his pulse was not elevated and during that particular phase there was no appreciable change, apparently.

Q. Following on down, can you tell us the next time you had reason to see the patient?

A. I myself?

Q. Yes.

A. By specific notes, my next visit to the patient, I believe, was at 4:45 the next day.

Q. 4:45 on June 11th? A. Yes.

Q. 1952? A. Yes.

Q. 4:45 in the afternoon? A. Yes.

Q. Are you able to indicate or advise us, between those times, whether Dr. Craig called upon the patient and when he called upon the patient, as shown by the record?

The Court: Recess until 2:00 oclock.

(Noon recess.) [70]

(Court reconvened at 2:00 o'clock p.m. Wednesday, July 21, 1954, pursuant to recess, and further proceedings herein were had as follows.)

(Last question read.)

A. According to this record, I find that Dr. Stalder and Dr. Craig saw the patient, I would

(Testimony of Dr. Constantine Otto Schneider.)
estimate, at 8:30 on the morning of June 11th, per the record.

Q. That information is in the nurse's notes?

A. Yes.

Q. Is it customary for a nurse to enter a note of the visit of a doctor when he sees a patient?

A. When she is in attendance at the patient's side, yes.

Q. Is it customary for a doctor to enter a note on the chart that he had seen the patient?

A. Not necessarily.

Q. Reviewing the bedside notes and the doctor's order sheet and the remainder of Exhibit No. 1, was any further treatment done or given to the actual wound other than the treatment given by you as described during the patient's stay in the hospital?

A. To the best of my ability and knowledge, I would say no.

Q. You have reviewed Exhibit No. 1 both now and before this trial?

A. I see no further reference.

Q. Does the record or your recollection of the case permit [71] you to say whether the patient was actually in shock at any time during his stay?

A. I feel he was in what we speak of as incipient shock. The reason for saying that is a clinical impression. There is no set rule for shock. It is a clinical impression that one gets from seeing a patient.

Q. With reference to the medication given,

(Testimony of Dr. Constantine Otto Schneider.)

Deprapanex, for ileus, will you state for the record what ileus is?

A. We speak of ileus as loss of relaxation of the bowels, bladder, and organs of that type. It causes loss of function, lack of function, and distention, and, in Mr. Morin's case, it resulted in the necessity of catheterizing at frequent intervals and things of that sort.

Q. At the time he came into the emergency ward, the emergency treatment room, would you say that ileus was impending or that he was actually suffering from it?

A. I would say it is impossible to say how long after the initial injury it would take for the ileus to develop, but I believe we first noted the onset of the ileus in relationship to the necessity for catheterization.

Q. Would you be able, from your own memory or from the records you have before you in Exhibit No. 1, to state when that was?

A. He was initially catheterized about 10:30 that evening.

Q. 10:30 that evening? [72]

A. Yes, at least as shown by the notes.

Q. You have testified you externally cleansed the wound with this sterile saline solution, and that you then bandaged the wound and, to your recollection, you applied a splint. Is that a fair statement of what you did?

A. That is correct, except I am not positive that I applied the splint at that time or after the X-rays

(Testimony of Dr. Constantine Otto Schneider.)
were taken, but I am sure I applied a splint to that man. That is customary.

Q. Did you debride the wound?

A. I did not.

Q. I beg your pardon? A. I did not.

Q. Did you close the wound——

A. No, I didn't.

Q. ——with sutures in any way?

A. No, I didn't.

Q. Did you attempt to reduce the fracture?

A. There was no evidence at the time that the fracture needed reduction.

Q. Did you clean the bones?

A. No, I didn't. The bone was not protruding, to the best of my recollection.

Q. Doctor, you have been handed Plaintiff's Exhibit No. 3, which is the clinical record of the U. S. Public Health Service, Marine Hospital, in Seattle. Is that correct? [73]

A. Yes, that is correct.

Q. Do you recognize that record?

A. I have never seen it before.

Q. You have never seen it previously?

A. No.

Q. Would you be kind enough, Doctor, to turn to the narrative statement of treatment?

A. The narrative summary?

Q. The narrative summary, I believe that is what it is called. A. Yes.

Q. Would you read therefrom, if you can, the

(Testimony of Dr. Constantine Otto Schneider.)
description of the laceration and the wound? Read it out loud, if you will.

A. Extremities: There was a laceration—do you want the whole thing?

Q. Yes.

A. "Physical examination: The patient is well developed, well nourished white male, who is in a semi-comatose state, probably due to narcotics and barbiturate was given and transportation. Pupils were equal but myopic. No response to light. Lungs clear to percussion and auscultation. Heart negative. Abdomen was rigid and slightly distended. Both stasis were hyperactive; there was no tenderness. Extremities: [74] There was laceration approximately a 12 cm. long and 4 cm. wide over the anterior mid shin, left with proximal bone fragment out through the wound. There was considerable dried blood around laceration with rather strong odor but no gross infection noted."

Q. Would that description of the wound be the same as your recollection of the wound?

A. I would say it would not.

Q. Would you say the wounds were larger than you recall?

A. In my recollection, there were two small wounds, the largest perhaps at the very most being two inches long.

Q. Was the bone protruding at the time you examined it?

A. Not at the time I had examined it.

(Testimony of Dr. Constantine Otto Schneider.)

Q. Would you turn to the summary of the operation, the first operation?

Mr. Page: Page 11.

Q. (By Mr. John D. Ryan): Is that the one?

A. That is it.

Q. Would you read the title of it? What is the title, for identification of what you are reading?

A. This is the "Operation Report" from the "Clinical Record."

Q. Is there a date there?

A. Dated 6/16/52. [75]

Q. Is there a date upon which the operation was performed?

A. The date of the operation, yes, 12th of June, 1952.

Q. The 12th of June, 1952. At what time, please?

A. 3:03 p.m.

Q. Will you read the description following the words "What Was Done" in that summary of the operation at the United States Marine Hospital in Seattle?

A. "What Was Done: The region of the lacerations, one about 1½ inches long and the other an inch long, was thoroughly scrubbed with soap and water, followed by a tincture of zepharin prep. With the leg draped the wound was gently irrigated with normal saline poured in from above and also through a bulb syringe inserted in about the fracture site. The clotted blood was removed from the region of the fracture with the finger inserted through the wound and the ends of the fracture

(Testimony of Dr. Constantine Otto Schneider.)
checked for adventitious tissue interposed over the fracture ends. With the leg supported in the Roger Anderson table with a sling under the knee and another sling attached to the ankle, traction was applied until the fragments which were overriding approximately one inch were brought into apposition. Traction was then released and with the position maintained as checked by palpation of the fractures the skin [76] wounds were sutured with simple and vertical mattress sutures of 00 cotton. Incomplete closure resulted because of the marked swelling of the tissues. However, the bone itself was covered. Sterile 4-by-4's were applied. The blebs were opened and the surface component excised and the base scrubbed with tincture of zepharin, after which sterile 4-by-4's were applied over these sites, also. The leg was then fixed with a plaster cast, well padded, extending high into the groin."

Q. Does that description of the wound, as given there, correspond with your observation of the wound?

A. As I remember, in addition to the two lacerations, there was a large abrasion in there.

Q. Was the bone visible at the time you saw the wound?

A. It was visible by separating the wound edges, as I remember.

Q. You were the resident at Physicians and Surgeons Hospital in Portland, Oregon, on June 10, 1952? A. Yes.

(Testimony of Dr. Constantine Otto Schneider.)

Q. What was your duty with relationship to patients of the U. S. Public Health Service when brought to the hospital?

A. They were the same as they were with any patient that was brought to the hospital. If there was an emergency status, something that required immediate attention, we tried to give [77] that emergency service as we would with any case, and if they were cases that were sent in covered by orders to be signed by the physician, then of course we did what we could.

Q. Did you get any direction of the physician under whose name the patient was entered?

A. Yes.

Q. In this case that physician was Dr. Craig?

A. That is right.

Q. He was with the U. S. Public Health Service at that time? A. Yes, that is right.

Q. I don't know whether I asked you this, but what was the type of fracture Mr. Morin had when you saw it? A. When I saw it?

Q. Yes, on the left lower leg.

A. I have not seen the X-rays since that time. As I remember, he had actually three fractures. He had a compound fracture of the left tibia; he had a compound fracture of the left fibula and, as I remember, he had a second fracture of the tibia.

Q. Is that confirmed by the hospital records?

A. I don't know.

Q. As resident physician at the Physicians and Surgeons Hospital in Portland at this time, June

(Testimony of Dr. Constantine Otto Schneider.)

10, 1952, did you feel fully competent to give the initial treatment required at the time of an [78] injury?

A. I would have preferred to have had some experienced surgeon working with us. I felt it was my responsibility, once I felt shock might be imminent——

Q. My question is: Would you have preferred to have had a more experienced surgeon with you?

A. Of course, it wasn't for training purposes we were there——

Q. I appreciate your answer, but would you have preferred to have had a more experienced surgeon work with you on this type of case?

A. I believe that would be logical for anyone, sir.

Q. Did you believe that this was a critical emergency?

A. By "critical" that it would terminate the patient's life? Probably not.

Q. Do you consider that this area of the left tibia is a critical area when it does have a compound fracture?

A. It sometimes is a little more difficult to handle.

Q. How would it apply to Mr. Morin, who was 42 at the time?

A. I believe you would have to ask an expert witness.

Q. In other words, you cannot answer that?

A. I am not qualified.

(Testimony of Dr. Constantine Otto Schneider.)

Mr. Harr: Speak louder, please. I find it difficult to hear.

A. I believe you should ask an expert witness. I am not here as an expert witness in this field. [79]

Q. (By Mr. John D. Ryan): I do not see any reason why you cannot answer it, Doctor, if you have the knowledge?

A. I am a general practitioner. I am not an orthopedic surgeon.

Q. Do you know anything about the lower left tibia? A. A little.

Q. Do you know anything about a compound fracture of the lower left tibia? A. Yes.

Q. If you found a wound within an hour of the time you had reason to know that a man had suffered a bone fracture, a compound fracture, I should say, of the lower left tibia, with all the other attendant injuries that you have noted here, would you then consider it a critical area for infection?

A. If it were a case of my own at the present time—you are asking my opinion now, not as of that time?

Q. I am asking your opinion as of that time. If you want to answer it as of now, you are free to do so.

A. In these particular cases in my particular status in the medical profession, I always have consultation.

Q. Then your answer is you would have preferred to have had consultation in this type of a case? A. If it were my own case.

(Testimony of Dr. Constantine Otto Schneider.)

Q. Would you have preferred to have had that consultation [80] immediately when you began the treatment of the patient or at some time later?

A. I feel in this particular case that consultation would be of no value over and above perhaps helping guide the course of the initial procedures.

We had attempted to control shock, which we feel we did. We had ordered X-rays. We had done the initial cleansing of the wounds. We had given antibiotics to prevent infection. We had immobilized the leg. That is just about all you can do in a case of this sort until such time as his condition——

Q. You are familiar with the Physicians and Surgeons Hospital, familiar with their facilities for full treatment of this man's condition?

A. Absolutely.

Q. Is it a Grade A or first-class hospital in the community? A. Yes.

Q. There are cases of this type treated there?

A. Frequently.

Q. To your knowledge, at this time was there expert consultation available for this type of case if you had cared to seek it? A. Yes.

Q. Would it have been available then within six hours or eight hours? [81] A. Oh, yes.

Q. From the time you saw the patient?

A. Yes.

Q. Was such expert consultation sought, to your knowledge?

A. I couldn't say, sir. After I called the

(Testimony of Dr. Constantine Otto Schneider.)
U.S.P.H. and wrote my initial orders, then I considered my responsibility in the case ended.

Q. You have the chart there still?

A. Which chart, the Public Health?

Q. Yes. Has that been taken from you?

A. No.

Q. Plaintiff's Exhibit No. 1. Does that show that expert consultation was sought at any time? Does the chart reveal that?

A. It shows that on the morning of June 11th at approximately 11:00 o'clock that Dr. Leonard had seen the patient.

Q. You admit Dr. Leonard was the type of consultation, expert consultant, you could call in?

A. He has seen a good deal of them.

Q. What kind of an expert consultant would be required?

A. Generally speaking, perhaps someone in general surgery or an orthopedic man, either one. Both of these specialists do orthopedic work.

Q. Do you have knowledge of what Dr. Leonard's specialty is? [82]

A. He is in general surgery.

Q. And he saw the patient on June 11th?

A. Yes.

Q. At what time of day?

A. At 11:00 o'clock.

Mr. John D. Ryan: That will be all.

(Testimony of Dr. Constantine Otto Schneider.)

Cross-Examination

By Mr. Harr:

Q. You say Dr. Leonard was not the type of doctor you had in mind, when you said it would have been better if you had consultation?

A. I think he would be fully qualified, yes.

Q. Fully qualified? A. Yes.

Mr. Harr: Would you hand the witness Plaintiff's Exhibit No. 3, the one he just had? We are referring to these as exhibits. I presume we may offer them all subject to whatever objections we may want to make.

The Court: They are all deemed received in evidence subject to any objections previously made or objections that may hereafter be made prior to the submission of the case.

Introduction of Exhibits

(The following exhibits were thereupon received in evidence:) [83]

Plaintiff's Exhibits

Description

No. 1—Photostatic copy of record of treatment of Amos Morin at Physicians and Surgeons Hospital, June 10 through June 12, 1952.

Nos. 2-A & 2-B—X-rays of Amos Morin taken at Physicians and Surgeons Hospital, June 10, 1952.

No. 3—Photostatic copy of hospital record of

(Testimony of Dr. Constantine Otto Schneider.)
Amos Morin of United States Marine Hospital, Seattle, Washington.

Nos. 4-A to 4-J—X-rays of Amos Morin, United States Marine Hospital, Seattle, Washington.

Nos. 5-A & 5-B—X-rays dated 8/19/52—Dr. Thorup.

No. 6—Hospital record of Amos Morin at Providence Hospital, Portland, Oregon.

No. 7—X-rays of Amos Morin, Providence Hospital, Portland, Oregon.

No. 8—Hospital record of Amos Morin, St. Vincent's Hospital.

No. 9—X-rays of Amos Morin, St. Vincent's Hospital, Portland, Oregon.

No. 10—Hospital record of Amos Morin, United States Veterans Hospital, Portland, Oregon.

No. 11—X-rays of Amos Morin, United States Veterans [84] Hospital, Portland, Oregon.

No. 12—Record of history of treatment of Amos Morin by Dr. Howard Cherry.

No. 13—Campbell's Operative Orthopedics, Volume I, C. V. Mosby, St. Louis, 1949.

No. 14—Pictorial Handbook of Fracture Treatment, Compere-Banks-Compere, The Year Book Publishers, Inc., Chicago, Illinois, Second Edition.

No. 15—Deposition of Lee A. Craig as an adverse witness.

No. 16—Deposition of Constantine Otto Schneider.

No. 26—Statements covering plaintiff's doctor and hospital charges.

(Testimony of Dr. Constantine Otto Schneider.)

Defendant's Exhibits

Description

No. 17—Specimen of bone chips, 7/11/52.

No. 18—Payroll and employment records, Dredge Wahkiakum.

No. 19—Textbook of Surgery, Christopher.

No. 20—U.S.P.H.S. Out-Patient Clinical Records.

Nos. 21-A & 21-B—U.S.P.H.S. X-rays, November 12 and 26, 1952.

No. 22—Attorneys' Textbook of Medicine, Roscoe N. Gray, M.D.

Nos. 23-A to 23-E—X-rays taken by Dr. Berg.

No. 24—Report and Office Memorandum of Dr. Warren C. Hunter. [85]

No. 25—Office Notes and Memorandum of Dr. Richard Berg.

Mr. Harr: We do have some medical textbooks, your Honor, which we perhaps may not want to leave and if we do want certain parts of the books in evidence, we can have them photostated and supplied later.

Q. Would you then refer to Page 11? You read from that particular page, but you did not read it all.

Mr. John D. Ryan: Page 11?

Mr. Harr: U. S. Public Health Service Records.

Q. Have you found it? A. Yes.

(Testimony of Dr. Constantine Otto Schneider.)

Q. The first paragraph is headed "What Was Found." A. Yes.

Q. Do you have that before you? A. Yes.

Q. I will ask you if the record says this: "The blood encrusted dressings and splints were removed * * *." Is that the language? A. Yes.

Q. That is just part of it? A. Yes.

Q. So, when the patient got to the Marine Hospital, in Seattle, there were dressings and there was a splint. As far as you know, there were no other doctors at the hospital that [86] did any bandaging or putting on of splints other than what you did?

A. To the best of my knowledge, that was all.

Q. You were the only one who performed any of those functions? A. Yes.

Q. Let us go back to the first part of your testimony. I would like to know a little bit about your background.

Ancker Hospital in St. Paul, is that a Class A hospital? A. Yes.

Q. Do they handle a large amount of emergency surgery? A. A great deal.

Q. Is it a modern hospital?

A. Very modern.

Q. Can you compare it to any hospital in Portland as to size and equipment?

A. About twice as big as almost any of the general hospitals in Portland that are available to the public; it is an 840-bed hospital that covers all services. The emergency service receives all emergencies from the entire City of St. Paul and Ramsey

(Testimony of Dr. Constantine Otto Schneider.)

County. The emergency service is probably the biggest in the city and probably equivalent to that of Minneapolis General in Minneapolis.

Q. You were there in the hospital as an [87] intern? A. That is right.

Q. How long was your internship?

A. One year.

Q. During the course of that time, as you have testified, you were in the emergency surgery?

A. Yes.

Q. Approximately how long were you in the emergency surgery?

A. As I remember, I believe it was a full 30 days that we have to put in.

Q. I presume you received, then, a lot of injuries, people involved in automobile accidents and more or less seriously injured people?

A. Yes.

Q. Including patients with bone injuries?

A. Yes.

Q. Fractures? A. Yes.

Q. Some compound fractures, perhaps?

A. Yes.

Q. Back fractures? A. Yes.

Q. When you said this morning you had personal knowledge of having taken an active part in one or two compound fractures of that type——

A. Yes. [88]

Q. There were other compound fracture cases you participated in? A. Yes.

Q. You didn't say, but I presume that while you

(Testimony of Dr. Constantine Otto Schneider.)
did not participate in treating other fractures, you were there and observed, is that correct?

A. That is right.

Q. Of course, in a hospital of that size they would have a great number of very highly skilled orthopedists and general surgeons? A. Yes.

Q. That you worked with and watched?

A. Yes. Training was under the University of Minnesota Medical School in that hospital.

Q. Was the treatment you followed in this instance comparable with the treatment you saw in connection with similar injuries while you were there in Ancker Hospital?

A. I believe the treatment that I gave this patient would be entirely comparable to that.

Q. State whether or not in your opinion a crushing fracture of the first lumbar vertebra is or is not a very serious injury?

A. In my opinion, I believe it is probably—I believe it probably far supersedes almost any type of fracture injury except perhaps a skull [89] injury.

Q. What was your first consideration? What was the thought you had in mind when you examined this man and felt it was your obligation and responsibility to give the primary treatment? What was the first consideration you had in mind?

A. I think my primary consideration in this case was to relieve his pain because the patient was extremely disturbed and complaining a great deal

(Testimony of Dr. Constantine Otto Schneider.)
of pain in the back, and alleviation of pain of course controls shock.

Q. You would say, then, his general condition was the first thing to be considered?

A. Yes, sir.

Q. In considering the general condition, what would be the danger signals that flashed before your mind that might develop in a situation, a condition that this man had, with a fractured back and serious leg injury?

A. Of course my primary care was shock because death can result from shock. My secondary consideration was the possibility of a back fracture which might result in dissection of the cord and, therefore, a complete paralysis.

Q. Is paralysis of the bowels usually or customarily an aftermath of a compression fracture?

A. In my experience it almost invariably results.

Q. In other words, that is an ileus?

A. An ileus. [90]

Q. Did it come about as you had anticipated?

A. Yes.

Q. There was a nurse in attendance at the time Mr. Morin came to the Physicians and Surgeons Hospital? A. Yes, sir.

Q. One of the first things you did was to administer some morphine? A. Yes, sir.

Q. Is the morphine cabinet in the surgery, in the room where you performed your surgery?

A. No, sir.

(Testimony of Dr. Constantine Otto Schneider.)

Q. What must be done to obtain access to the morphine so that you may have it administered?

A. At the time I was resident the morphine was kept under the direct supervision of the nurses' supervisor on that floor and any nurses who were given orders to give morphine had to go to the supervising nurse's office to get that morphine.

Q. What about penicillin?

A. I believe at that time—I am not quite positive—that while I was resident there we started a medication drawer in the emergency room. I don't know whether that was functioning at that time or not, but initially when we first went there we had to go to the nurse's office to get penicillin from there. Whether they were still doing it at that time or [91] whether we had this medication in the emergency room in a locked drawer, I can't say.

Q. You testified about irrigating the wound and giving it some cleansing. Do you have any personal recollection that a nurse was in the room at the time you gave that treatment?

A. I don't know. We were pretty busy.

Q. Do you have any recollection of the number of people that went in and out of the surgery and the patients you personally had to treat and care for?

A. I couldn't say. I imagine we got in that hospital between 100 and 110. The emergency service at that particular hospital varied a great deal. They didn't get much in the way of city cases in that hospital for emergency care, because it is a small hos-

(Testimony of Dr. Constantine Otto Schneider.)

pital. I couldn't estimate, but I would say we would probably run anywhere from perhaps 6 or 8 up to 20 in the emergency room on various days.

Q. And then perhaps 100 or more in the hospital? A. In the hospital, yes.

Q. I think when your deposition was taken you made some comment that there was no rule that when a person is given emergency treatment that you had to make any notation. Is that correct?

A. It is customary, but as far as I know there is no specific law or rule that says one has to be made, or anything. [92]

Q. Or to make charts, do you know about that?

A. I think there has been a record made on all cases, but I can't say definitely. Ordinarily in a case where a patient is admitted to a hospital from an emergency room there is no emergency record made, because that is usually incorporated in the total records which in this particular case I did not write, the admittance note.

Q. Can you account for the fact you did not write that? I think you said once you tried to do that very thing.

A. We try to write as many as we can, but at times we get too busy and do not get an opportunity to go back and catch up on notes, and that quite possibly could have happened here.

Q. When Mr. Morin came into the emergency room, you made a cursory examination, and you heard Mrs. Morin this morning testify that you said you were going to have to cut his trousers. Do

(Testimony of Dr. Constantine Otto Schneider.)
you remember about that? Do you remember about cutting his trousers?

A. I can't remember, frankly, whether we took them off or cut them off. I can't remember.

Q. Then you testified as to the detergent and mild antiseptic used. In what area or over what area did you use that antiseptic and detergent?

A. I used that around the area immediately surrounding the open wound, and then attempted to wash out any bacteria or [93] contamination that might be present.

Q. Do you have any recollection as to whether or not it was bleeding?

A. I think there was minimal bleeding at the time I saw it. There was blood present, as in any wound, but at that time, as I remember it, it was quite minimal.

Q. In your experience, if you find an area of the sort that has been described, you are concerned with contamination that might get into the wound? Is that correct?

A. If it is bleeding, then you have to scrub it and if something is scrubbed there is necessarily a contamination.

Q. After you used the antiseptic and detergent around the wound, then what did you do to it?

A. As I remember, we applied a dry sterile dressing.

Q. Well, before that?

A. As I remember it, we cleaned the abrasion.

Q. You first cleaned the abrasion?

A. Yes. Then we poured some of the saline solu-

(Testimony of Dr. Constantine Otto Schneider.)

tion, as I remember it, all over the wound in an attempt to clean it; that is to wash out any dirt or bacteria that might be present. After it was thoroughly cleaned, then we applied a large compression dressing over it.

Q. Counsel asked you something about excising the wound or about debridement.

A. By strict definition, debridement involves removing of [94] foreign matter and excision of all the tissues immediately surrounding the wound, after you irrigate the wound and wash the dirt out of it.

Q. Was there any such tissue in this case, as far as you recall, that needed to be excised?

A. To the best of my recollection, no, there wasn't. I couldn't find any. The wounds were small, and there didn't appear to be any.

Q. As to the dressings you put on there, you said you put a compression dressing and then you put on some Ace bandages? A. Yes.

Q. Does that have any tension to it or——

A. It is slightly elastic.

Q. How many bandages of that kind did you put on?

A. I couldn't recall exactly. I would say perhaps in an area that large perhaps two, maybe three.

Q. Reading from the nurse's notes, I see that there is a notation there of three packages of compression cotton, four three-inch Ace bandages and one six-inch Ace bandage.

A. That could very well be the coverage, apparently.

(Testimony of Dr. Constantine Otto Schneider.)

Q. You told me personally, Doctor, a while ago when I was talking to you about your recollection of the size of those bandages to bandage the leg when he left the emergency surgery. Would you indicate with your hands, as you recall, the size so the Court can see? [95]

A. I would say the bandage altogether was approximately that big (illustrating) around over his entire leg.

Q. Why did you feel it necessary to put on such dressings and to splint it as you did?

A. I wanted—the patient was a little bit or quite a little disturbed and I wanted to immobilize the leg to prevent further damage.

Q. Did you have in mind at that time that, in all likelihood, there would be no further surgery or that there might be surgery in the case?

A. Well, I can't really state, sir, because as far as further surgery was concerned, just from my own personal opinion of the patient's condition at that time, I would say it indicated immediate emergency care, but I had no further responsibility in making any decision in that case.

Q. You then sent him to X-ray? A. Yes.

Q. And then to bed? A. Then to bed.

Q. Was he put in an extension on the bed?

A. Yes; when we sent him to bed we had the leg elevated on pillows to help control the swelling and bleeding, and we had to place him in such a position that the back was in what we call hyperextension. It can be elevated—the bed, I mean—in that way,

(Testimony of Dr. Constantine Otto Schneider.)
or you can place a blanket or something under [96] the patient's back.

Q. What is the purpose of that extension?

A. Generally, patients with compression fractures, the spine is placed in hyperextension to help prevent any possibility of bad effects on the spine.

Q. Would it also tend to pull that compression fracture—to pull it back to its proper shape?

A. It would; it would probably tend to help.

Q. On direct examination you testified you called Dr. Craig and that your recollection was that you also talked to Dr. Leonard. You do recall that Craig told you Dr. Leonard would be brought into the case, is that correct?

A. I believe so. That is what he stated.

Q. Should consideration in a case like this be given to not aiding the distress at the outset by taking a man to regular surgery to reduce his fracture and giving him an anesthetic? Is that a consideration which doctors take into account, the complications of surgery?

A. Most surgeons fear shock under general anesthesia. The patient was, in my opinion, at that time in impending shock or incipient shock, and anesthesia would not be indicated at the time I examined him.

Q. I notice, in looking at the hospital chart, it shows the temperature went from 99 at the time of admittance up to 100.2—that would be 99.2? [97]

A. Approximately.

Q. I notice, also, that his pulse went from 84

(Testimony of Dr. Constantine Otto Schneider.)
upon admittance to 112 the morning of June 11th. Is that correct?

A. Yes; by the record, that is right.

Q. Does that pulse rate have any significance?

A. I believe it does, sir. All the major textbooks on surgery that I have read indicate that one of the first indications of impending shock is a rise in the pulse rate, rather than a fall in pressure, the fall in pressure coming later.

Q. By looking at the chart, from the time of admittance until the pulse rate reached 112, the graph shows a straight line up, doesn't it? A. Yes.

Q. Would you have considered it good practice to have taken such a man direct to surgery and given him a general anesthetic, a man that was in that serious condition?

A. I think that someone more specialized in surgery than myself would be more qualified to answer that question.

We did have blood ready in event of shock and had made preparations which we felt were necessary to forestall shock, but I do not feel qualified to answer that question as to the possibility of shock.

Q. Do you know from your experience or from observing others [98] handling cases of this kind, or authorities that you have read, whether or not the administering of a general anesthetic would have increased the likelihood of shock?

A. Textbooks on surgery specifically set forth one of the causes of surgical shock is general anesthesia, or can be, I should say.

Q. Turning over to the bedside notes, Doctor,

(Testimony of Dr. Constantine Otto Schneider.)

the nurse's bedside notes show his blood pressure between 3:00 and 4:00 o'clock at 140 over 88. Then I see they administered under your direction Dromaron. A. Yes.

Q. What was the purpose of that?

A. The patient at that time was still complaining—in spite of the fact that he had already had narcotics, he was still complaining of intense pain in his back.

Q. At 5:45, 1 cc. Dromaron. Was that for the same reason? A. That is right.

Q. At 9:00 o'clock we find 400,000 units of penicillin. A. Yes, sir.

Q. And at the same time 4 cc. of Deprapanex.

A. Yes. That was when we were expecting the ileus to develop.

Q. The paralysis of the bowel that you spoke of?

A. Yes.

Q. Later that night I see the medicine administered was [99] Sedamyl? A. Yes.

Q. What is the purpose of that?

A. The patient still had not apparently had his pain completely controlled and Sedamyl had to be given as a general sedative, a mild sedative, to try to help relax the emotional aspect.

Q. I notice an entry here at 10:20, Dromaron 1 cc. "for pain in back." Is that correct?

A. Yes.

Q. At 10:30 he was catheterized? A. Yes.

Q. And Dromaron again at 3:40 in the morning?

A. Yes.

(Testimony of Dr. Constantine Otto Schneider.)

Q. On the morning of the 11th Deprapanex, 4 cc. again. That was for the ileus?

A. For the ileus, yes.

Q. And again penicillin? A. Yes, sir.

Q. Did you not order and was there not given glucose intravenously to supply loss of moisture in the system?

A. I believe he was given that while he was there. I will have to check the records. Yes, he was given 10 per cent glucose in water, distilled water.

Q. That was at 10:30 at night, the night of the 11th, is [100] that correct? A. Yes, sir.

Q. All of these medicines and treatment had been followed by your initial orders?

A. I believe the bulk of it had been. There were some changes made by Dr. Stalder who changed my initial order from morphine sulphate to Dromaron and then later he increased that dosage himself.

Q. Is it the usual practice for doctors to make the rounds of the hospital in the morning?

A. Generally, yes.

Q. Then, for the balance of the day, is it ordinarily not a fact that they expect the resident physician to keep somewhat in touch with the patient and to know how he is progressing?

A. That is right, sir.

Q. And, unless he receives a telephone call, does he not have the right to assume that there has at least been no change for the worse? A. Yes.

Q. Doctors Craig and Leonard, who saw him on the morning of the 11th, apparently relied on you

(Testimony of Dr. Constantine Otto Schneider.)
and Dr. Stalder to keep them informed in case of a change? A. Yes.

Q. I notice on the morning of the 12th he ate a light diet, [101] had a light diet, consisting of one-half serving of cereal, coffee and a soft egg, is that correct? A. On the morning of the 12th.

Q. Yes, before leaving for Seattle?

A. Yes, sir.

Q. Then I notice Dromaron, 1 cc., again, administered at 9:30? A. Yes, 9:30—no, 7:50.

Q. 7:50, I believe it is. A. Yes.

Q. Then at 8:00 o'clock it shows, "Transferred by ambulance to Seattle." A. Yes.

Q. Were you on duty at the time he left for Seattle? A. No.

Q. Was Dr. Stalder on duty? A. Yes, sir.

(Recess.)

Mr. Thomas H. Ryan: If the Court please, we have Dr. Cherry here, but we would just as soon not have him come until tomorrow afternoon at 2:00 o'clock. I do not think we will reach him until that time, although we might have to adjourn a little early tomorrow at noon if that is all right with the Court. [102]

The Court: How long are you going to take to try this case, all summer?

Mr. Thomas H. Ryan: No; I think we will be finished tomorrow.

(Testimony of Dr. Constantine Otto Schneider.)

Cross-Examination
(Continued)

By Mr. Harr:

Q. Dr. Schneider, on direct examination I believe you made this statement, that you saw the ends of the bone in the wound but they did not show through? A. Yes.

Q. Counsel asked you whether or not you had reduced the fracture, and I think your comment was you saw no need to reduce the fracture. Will you state what you had in mind when you made that statement? Do you recall giving that answer?

A. I believe I said that.

Q. Would you explain why you made that comment?

A. Well, at that time the patient was in what we will describe as a somewhat rocky condition, and I could see no reason at that time for my attempting any manipulation which might cause further tendency to push him into shock, if shock were impending, or anything of that sort. His condition was not stable, in my professional opinion at that time. [103]

Q. Did you not have in mind that you at that time were acting in an emergency capacity?

A. Yes.

Q. If there had to have been surgery and a reduction of the fracture, then that would fall to the duty of those to whom the case was assigned?

A. Yes.

Q. In other words, Dr. Craig and Dr. Leonard?

(Testimony of Dr. Constantine Otto Schneider.)

A. Yes.

Q. If you had this whole thing to do over again, would you have varied your treatment in any degree? A. My initial care?

Q. Yes. A. No, sir.

Q. Would you have changed it in any respect?

A. My initial care, I would not.

Mr. Harr: That is all.

Redirect Examination

By Mr. John D. Ryan:

Q. You said, if you were asked to do this same thing again, that your initial care would not have varied?

A. In my initial care, until the patient was put to bed and I had notified the physician in charge of the case, I think I would have made no [104] change.

Q. You are bringing that to the time you telephoned to Dr. Craig? A. Yes.

Q. Would you have sent the patient to Seattle under the same circumstances, if you had to do it over again?

A. I am not here as an expert witness.

Mr. Harr: If your Honor please, I think that is objectionable.

The Court: Objection sustained.

Q. (By Mr. John D. Ryan): Doctor, you said you were concerned with the condition of the fracture of the second lumbar vertebra, that it had given you serious concern? A. That is right.

(Testimony of Dr. Constantine Otto Schneider.)

Q. In terms of treatment, what was your intention? Did that involve putting the man in bed?

A. Oh, yes. You mean my initial care?

Q. Yes.

A. In bed and in hyperextension; that is, with his back arched.

Q. Was it your intention to immobilize the man in that respect? A. You mean immediately?

Q. Yes.

A. In most cases it is not necessary to immobilize immediately. Hyperextension is common treatment of these fractures [105] in itself.

Q. You did put him in hyperextension?

A. I did put him in hyperextension.

Q. You deemed that to be sufficient and the best thing for him at that time?

A. Adequate at that time.

Q. With respect to his condition, you said he was in incipient shock?

A. That is the term I used.

Q. In the course of his treatment he never went into actual or complete shock?

A. Not into complete shock.

Q. You were not certain as to the inception of the ileus, but you do know you catheterized at 10:30 on the night of the 10th? A. Yes.

Q. But you were fearful of it coming on some time? A. Yes.

Q. Was there any other factor that weighed upon your mind with regard to any further treat-

(Testimony of Dr. Constantine Otto Schneider.)
ment, postponing any further treatment other than the ileus and incipient shock?

A. I believe those two factors, plus the fact that the man had a compression fracture of the spine. My personal opinion was—I would imagine at the time—that until we had the pain from the back, which was the outstanding single factor, [106] under control, that the man could have gone into shock at that time.

Q. Did you ever get it under control?

A. The pain?

Q. Yes.

A. It started to come under control, I believe—may I refer to the record?

Q. Yes.

A. It apparently started to come under control approximately in the afternoon of the 11th, in regard to pain.

Q. On the 10th, at 3:00 p.m., did you take the blood pressure that is recorded?

A. At 3:00 p.m.? There is one recorded here at 4:45 on the afternoon of the 11th.

Q. What is that?

A. Blood pressure. Is that the one you mean? 130 over 90?

Q. I am asking about June 10th.

A. The blood pressure at 3:00 o'clock was 140 over 88.

Q. Is that a good blood pressure?

A. It is not, in case of an injury.

(Testimony of Dr. Constantine Otto Schneider.)

Q. When you speak of postponing further definitive treatment, would you admit the operation that was performed which you have read a description of, performed on June 12th, 3:03 p.m., in Seattle, would you admit that to be definitive treatment? A. How do you mean, sir? [107]

Q. You stated you felt no further treatment should have been undertaken to the leg at this time because of the considerations you have stated?

A. At the time I had some responsibility for the case, and that was only a period of approximately an hour or an hour and fifteen minutes—during that time I felt until I had notified the staff physician, I felt nothing could be done during my time of responsibiltiy.

Q. Considering those factors, would you say that the treatment described in the operation—you read a description of the operation into the testimony here, the operation performed up in Seattle. Would you say that would have been proper and definitive treatment?

A. I would have to look at that again.

Q. I believe it is on Page 11 of Exhibit No. 3.

A. That again concerns strictly orthopedic procedures done by an orthopedic surgeon. I don't think I am qualified to answer that.

Q. Let me ask you the question this way: You said you did not feel anything further should be done. You have expressed an opinion as to that in your testimony. Then you said nothing further

(Testimony of Dr. Constantine Otto Schneider.)

should be given to the patient because of the considerations which you have enumerated; one, the possibility of shock and, the other, the ileus proposition; and you also said he did not go into incipient shock and he never did go [108] into shock, and you didn't know when the onset of the ileus was other than you had him catheterized at 10:30 the night he was brought into the hospital. What did you have in mind as to what should be done further?

A. You are asking me for my opinion of definitive treatment?

Q. I am asking you what you meant by your remark that you did not think anything further should be done to the patient. The fact is that you were at least in attendance upon the patient and that you did all that could be done under the circumstances, you claim. I am asking you whether if these circumstances had been controlled, would you deem this treatment here to be the next which would have been done in this case?

A. This one here?

Q. Yes.

A. I believe that would have been satisfactory.

Q. At the Ancker Hospital, after giving emergency treatment, you said they went to the surgery floor. Would that be the customary thing to do with a compound fracture?

A. This would have been adequate procedure, yes.

(Testimony of Dr. Constantine Otto Schneider.)

Q. At Ancker Hospital what would be the time interval between emergency treatment, X-rays and then to the surgery floor?

A. They would go to surgery, but that doesn't mean—they would go to the surgery floor. The floors are divided according [109] to service. They might go to the surgery floor and it might be a day or two or it might be a couple of weeks before a case of this kind was operated. I can't say. That is specialized procedure. It would not be my responsibility to make a decision of that kind.

Q. Who would make that decision, in the way of specialists? A. Anyone called in consultation.

Q. Anyone called in consultation? What kind of a doctor would be called in consultation?

A. In this particular case a general surgeon was called in consultation at the Marine Hospital, apparently an orthopedic surgeon.

Mr. John D. Ryan: I have no further questions.

Recross-Examination

By Mr. Harr:

Q. You said you talked to Dr. Craig and you talked to Dr. Leonard. Did you inform them completely as to what you had done for Mr. Morin?

A. I believe when I talked to—if I remember correctly, when I talked to Dr. Craig, I think I might even have mentioned the man was having severe pain and apparently had a fracture of the back.

(Testimony of Dr. Constantine Otto Schneider.)

Q. In other words, the fact is that they had accepted the original treatment you had given? [110]

A. Yes.

Q. And you assumed from that that they knew exactly what you had done. Do you know that you did notify them? A. I believe I did.

Mr. Harr: That is all.

Redirect Examination

By Mr. John D. Ryan:

Q. Do you know that you informed them of what you did?

A. When I talked to Dr. Craig, I explained the procedure we had carried out and suggested the necessity of X-rays, to the best of my recollection.

Q. To the best of your recollection did you tell him what you did in emergency surgery?

A. You mean the specific procedures?

Q. Yes.

A. I may not have described them completely.

Q. Did Dr. Craig ask you what you had done to the patient in emergency surgery?

A. I can't remember exactly. I really couldn't answer that. I couldn't remember if he asked me specifically or whether he did or not.

Q. Did Dr. Leonard ever ask you?

A. I can't answer that, either. I believe my major discussion was with Dr. Craig. [111]

Q. You know Dr. Albert Morrison of the U. S. Public Health Service? A. Yes.

(Testimony of Dr. Constantine Otto Schneider.)

Q. Did he ever ask you about it? A. Yes.

Q. When I am asking you these questions, I am referring to the period during which the patient was under treatment and particularly June 10, 1952.

A. Just the period in the emergency room.

Q. I am referring to the period during which he was in the hospital, at Physicians and Surgeons Hospital, on June 10, 1952.

A. The entire period?

Q. I am saying June 10, 1952, first.

A. Just June 10th?

Q. Yes.

A. I don't think I was ever in contact directly with Dr. Morrison.

Q. Would the same answer apply with regard to your recollection as to whether they specifically asked what had been done for the patient, would it apply to June 11th or the morning of the 12th?

A. I believe so. I don't remember ever having been in contact with any of these physicians on either the 11th or 12th.

Q. Would that apply to all the gentlemen I have named? [112] A. Yes.

Q. Did you say you talked with Dr. Leonard?

A. I beg your pardon. You mean on the initial day?

Q. Yes.

A. I believe I did. I can't remember specifically, but I think I called him; but I can't remember whether Dr. Craig said he was going to call him

(Testimony of Dr. Constantine Otto Schneider.)
or whether I was to call him. I can't remember that.

Mr. John D. Ryan: No further questions.

Recross-Examination

By Mr. Harr:

Q. The only purpose you had in calling Dr. Craig was to tell him about the patient and to tell him what his trouble was? A. Yes.

Q. I think you said after the X-rays were taken you talked to him again?

A. I believe that is correct.

Q. And the object of your calling him was to inform him of what you had done and what you found out? A. That is correct.

Mr. Harr: That is all.

(Witness excused.) [113]

DR. LEE A. CRAIG, JR.

produced as a witness on behalf of Plaintiff and, being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. John D. Ryan:

Q. You are Dr. Lee A. Craig? A. Yes.

Q. You are an M.D.? A. Yes.

Q. Would you tell us your qualifications in terms of education up until June 10, 1952?

A. I took my premedical training at Westminster College at Fulton, Missouri, and also at Leland Stanford University in California. I then took my

(Testimony of Dr. Lee A. Craig, Jr.)
medical training in the St. Louis University Medical School in St. Louis, Missouri.

From there I took my internship at the U. S. Marine Hospital in Seattle, Washington, and from there, in the summer of 1949, I was transferred to the U. S. Public Health Service out-patient clinic at Portland, Oregon, where I performed general clinic and hospital duties essentially of the same type as I was performing at the time Mr. Morin was injured.

Q. The general clinic and hospital duties, what would those consist of, Doctor?

A. Well, we had an out-patient clinic at the U. S. Court House, in this building, where we took care of all types of [114] medical and surgical problems and patients requiring hospitalization were hospitalized at the Physicians and Surgeons Hospital. They were sent there by us and by our designated consultants.

Q. Did you actively, yourself, treat patients at the Physicians and Surgeons Hospital?

A. Yes.

Q. You mentioned consultants designated by the U. S. Public Health Service. Was it your duty or your job to call in consultants at the time you deemed one was needed?

A. I would say yes, subject to the approval and consent of Dr. Morrison.

Q. Who is Dr. Morrison?

A. Dr. Morrison is the medical officer in charge

(Testimony of Dr. Lee A. Craig, Jr.)
of the U. S. Public Health Service out-patient clinic in Portland.

Q. Do you recall treating Amos Morin at the Physicians and Surgeons Hospital in Portland, Oregon? A. Yes, I do.

Q. Was Mr. Morin entered in the hospital under that name on June 10, 1952? A. I believe so.

Q. Do you recall personally this particular case, of your own recollection? A. Yes.

Q. Have you also had reason to refresh your memory by consulting [115] the records involving this case? A. Yes.

Q. Have you had reason to consult with the other doctors concerned with this case?

A. Some of the doctors.

Q. What doctors have you talked to about this case?

A. I talked to Dr. Morrison and briefly to Dr. Leonard and also to Dr. Schneider, and I think that is all.

Q. Dr. Leonard—what is his full name, please?

A. Dr. John B. Leonard, I believe.

Q. What was his relationship to the United States Public Health Service in June, on June 10, 1952, and during the time Mr. Morin was treated at Portland?

A. At that time he was a part-time consultant for the U.S.P.H., at the Physicians and Surgeons Hospital.

Q. By "part-time consultant," what would his duties be?

(Testimony of Dr. Lee A. Craig, Jr.)

A. Well, in his capacity as general surgeon he would give consultative service and do surgery upon such cases as we thought required his attention.

Q. At this time you say he was a general surgeon? A. Yes.

Q. At this time was there an orthopedic surgeon acting as consultant to the U. S. Public Health Service? A. Yes, I believe there was.

Q. Who was he? [116]

A. The only one I recall or remember specifically is Dr. Kimberley.

Q. What is his full name?

A. A. Gurney Kimberley, I believe.

Q. A. Gurney Kimberley? A. Yes.

Q. Is he at present practicing in Portland, Oregon, to your knowledge? A. Yes.

Q. You say he is an orthopedic consultant?

A. Yes.

Q. To your knowledge, that is his specialty?

A. Yes.

Q. He was a consultant with the U. S. Public Health Service? A. Yes, he was.

Q. And that was his duty at the time Mr. Morin was in the hospital?

A. I believe that is correct, yes.

Q. Were there any other consultants, as we call them, in the U. S. Public Health Service at that time that you can recall?

A. We had a number of doctors in various specialties that were called in suitable cases. We were free, actually, to use almost any bona fide specialist.

(Testimony of Dr. Lee A. Craig, Jr.)

Q. I see.

A. In other words, we were not bound by a list or required [117] to use any one doctor in any one specialty, necessarily.

Q. Am I to understand, then, you would be free, if you felt the case required it, to call upon any orthopedic specialist as the need might arise, if you thought an orthopedic specialist were necessary for the treatment of a patient?

A. That is correct.

Q. And, similarly, if there were some other problem involved, you would be free to call upon some other specialist on the same basis?

A. Yes.

Q. Have you familiarized yourself with these charts of the Physicians and Surgeons Hospital concerning Mr. Morin's treatment?

A. I have looked at it several times, but I don't know it verbatim. I will take it, if you are going to refer to it.

Mr. John D. Ryan: Will you hand that to Dr. Craig?

Q. When were you first informed, Doctor, of Mr. Morin's presence at the hospital, the Physicians and Surgeons Hospital in Portland, Oregon?

A. I would say it was shortly after he was admitted to the hospital. I would say, just as a guess, within an hour.

Q. Are you capable of saying what the time of admission was?

A. No; I don't remember it. [118]

(Testimony of Dr. Lee A. Craig, Jr.)

Q. Who notified you or informed you of it?

A. I do not have a clear recollection. I know it was either the girl in the emergency surgery or Dr. Schneider himself.

Q. Are you able to say what was said to you when you were informed?

A. I know I was told he had a fractured left leg. I am not clear as to whether or not at that time I was informed—I am speaking of the very first call, my notification that he was there. I am not sure that I was told he had a fracture of his lumbar spine, and I think it is possible, perhaps, that I was not, inasmuch as the X-rays had not yet been taken.

Q. You say a fracture of the left leg?

A. Yes, informed——

Q. Were you informed that it was a compound fracture?

A. I believe so, but I do not have an independent recollection of it.

Q. Where were you when you were informed?

A. I believe I was at the clinic, because at that time of day I would be down there seeing patients.

Q. By the "clinic," you mean the U. S. Public Health Service Clinic? A. Yes.

Q. That is here in the United States Court House? A. Yes. [119]

Q. Can you tell us what directions you gave to Dr. Schneider?

A. He, of course, told me what he thought was wrong with the patient and, up to that point, what he had done. I think we agreed that the patient

(Testimony of Dr. Lee A. Craig, Jr.)

should have X-rays, and then, of course, I was to be notified when the reports were in or when the X-rays had been seen by Dr. Schneider.

Q. You say he informed you what had been done. What did he tell you had been done to the patient at the time he called?

A. He simply said the leg had been uncovered and was being dressed and cleaned.

Q. Was being dressed and cleaned?

A. Yes, sir.

Q. You don't know whether at the time he called you it had already been dressed and cleaned?

A. I don't know whether, for instance, he stepped in and took the pant leg off and looked at it or stepped out and called me or whether he had already done that and called me. I don't recall.

Q. Your memory is hazy on that point?

A. Yes.

Q. Could you tell me why Dr. Schneider called you?

A. Well, it was customary to have one of the medical officers responsible for admissions and the care of patients at the hospital at all times, both day and night, and if a [120] patient was taken to the hospital in the daytime, such as this, they would call us and tell us what was wrong with the patient and we would then advise them as to what should be done.

Q. Would that be in your capacity as an officer in the U. S. Public Health Service? A. Yes.

Q. I note that the patient was entered under

(Testimony of Dr. Lee A. Craig, Jr.)

your name. Were you the attending physician to this patient, then?

A. Well, actually, this patient was a U. S. Public Health Service patient and, as such, it was the responsibility of the group, you might say, at this clinic.

However, since I was on call or I was on duty at that time, my name was simply entered as the admitting doctor.

Q. At the time you got this telephone call, you say he indicated X-rays should be taken. Were those your orders to Dr. Schneider?

A. Well, I don't recall that I directed him specifically. I mean, that is the logical step, or he may have said, "I think we are going to send him down to X-ray," and I could have said, "All right, that is fine. Go ahead and do it."

Q. Was there any discussion at that time regarding surgical procedure?

A. Not in that initial call, certainly not.

Q. Excuse me? [121]

A. No. The point was to find out what was wrong with the patient and decide what was to be done.

Q. At any time during the patient's stay in the hospital—June 10th, June 11th or June 12th—was there any discussion about surgical procedure, other than emergency care?

A. Yes, I think it was discussed.

Q. With whom was it discussed?

(Testimony of Dr. Lee A. Craig, Jr.)

A. I am sure I discussed it with Dr. Morrison, also with Dr. Leonard.

Q. What possible surgical procedures were considered?

A. Well, the only thing that we did—the only thing that needed to be done, in addition to what was done, would be final reduction of the fracture site and application of a plaster cast to the leg.

Q. Would that final step involve closure of the site? A. It might.

Q. Was that what was discussed? A. Yes.

Q. That was discussed with whom, please?

A. Dr. Leonard and Dr. Morrison.

Q. When did that discussion take place?

A. When the patient came in on the 10th—is that the first day?

Q. June 10th is the first day. The record shows he came in about 1:15 p.m. [122]

A. As soon as I found out what was wrong with the patient I, of course, conferred with Dr. Morrison. Then we agreed Dr. Leonard would be asked to consult with us and help us in our care of the patient.

I also talked again to Dr. Morrison the following morning after I had seen the patient and on the afternoon, then, of the same day, the 11th, there was further discussion as to whether they were going to keep Mr. Morin here in Portland or send him to Seattle.

Q. Did you talk to Dr. Leonard on June 10th, the day Mr. Morin was taken to the hospital?

(Testimony of Dr. Lee A. Craig, Jr.)

A. I don't recall whether I talked to him or not. I know he was notified, but whether I did or Dr. Stalder or Dr. Schneider—I know the matter was discussed as to his present condition.

Q. Did you, as general physician or as physician in whose name this man was entered in the hospital, know what Dr. Leonard advised regarding treatment on June 10th?

A. I think we certainly agreed that he should be watched closely and, as soon as emergency care was given, he should be put to bed.

Q. Did you discuss with these gentlemen the question of whether he should be kept in Portland or sent to Seattle? A. That day?

Q. Yes. [123] A. No.

Q. Did you discuss that on June 11th?

A. Yes, I think so.

Q. With respect to the patient's condition of health, why was it determined that he should be sent to Seattle?

A. I don't think it was purely his health that was a consideration for sending him to Seattle. Once we had agreed that it did not change the prognosis with regard to the healing of either his leg or back, and since his condition was felt to be satisfactory, then we agreed that he could be sent to Seattle, which was the regular procedure at this clinic in Portland.

Q. If the patient's condition warranted it, would the U. S. Public Health Service keep a patient in Portland and treat him at the Physicians and Sur-

(Testimony of Dr. Lee A. Craig, Jr.)

geons Hospital? A. Yes.

Q. Was the Physicians and Surgeons Hospital equipped and capable of caring for a patient in this condition, to your knowledge? A. Yes.

Q. Was it a Class A or a Grade A hospital in this community in Portland, Oregon? A. Yes.

Q. Was the question of expense considered in any of these discussions as to whether the man should be kept here or sent [124] to Seattle?

A. Well, that, of course, would be a consideration. If there were nothing else to influence the opinion, certainly the matter of expense would be a consideration, simply because there is the Government Hospital in Seattle to which they may send patients, whereas this private hospital is employed on a contract or fee basis, and if there is a bed in Seattle that might be occupied, it certainly is cheaper for the Government, for the taxpayers, to send him there.

Q. When did you first see the patient?

A. I saw him in the morning, the next morning after he was admitted. In other words, if he were admitted on the 10th, I saw him the morning of the 11th.

Q. On the 10th did you personally attempt to contact any consultant or specialist or any other doctor to have him go on the 10th and see the patient and treat the patient on the 10th?

A. None other than Dr. Leonard.

Q. To your knowledge, did Dr. Leonard go to see the patient on the 10th?

(Testimony of Dr. Lee A. Craig, Jr.)

A. No, I don't think so.

Q. Did you at any time on the 10th of June, 1952, consult an orthopedic man about this case?

A. No.

Q. Did you request that an orthopedic man be consulted, [125] through your office? A. No.

Q. You say you first saw the patient on the 11th? A. Yes.

Q. About what time was that, Doctor?

A. It was—it is my recollection it was about 9:00 o'clock in the morning.

Q. Your recollection is fortified, I take it, by the nurse's chart? A. Yes.

Q. Were you in the company of anyone?

A. I was with Dr. Stalder.

Q. Who is Dr. Stalder?

A. He was another resident serving at the Physicians and Surgeons Hospital.

Q. At that time were you informed of the condition of the patient?

A. Dr. Stalder told me how the patient had been doing, and we looked at him.

Q. What did he tell you?

A. He simply said he had been in a lot of pain, and he described the case from there on, the procedure Dr. Schneider had carried out when he was admitted, and we agreed then we would follow Dr. Leonard's recommendations in this case.

Q. What were Dr. Leonard's recommendations in the case? [126]

A. Well, he felt the patient's condition was poor

(Testimony of Dr. Lee A. Craig, Jr.)

and that certainly we could not attempt to manipulate this leg any further until it improved sufficiently.

Q. Did Dr. Leonard tell you that directly?

A. I think he did, yes.

Q. Did Dr. Leonard, either on June 10th or June 11th, discuss the question of a simple closure of the wound?

A. No, I don't think that was a matter for discussion.

Q. When you saw the patient, I believe in your deposition you said he was in a ward, Ward C, at the Physicians and Surgeons Hospital?

A. Yes.

Q. Will you tell us what you observed with regard to the patient, where he was, and what the condition of his leg was, and of his back?

A. Well, he was simply lying in bed on his back, flat in bed, with his head down, and his left leg was raised up on pillows, and he was encased in a large bulky dressing of cotton from up above the knee down to the foot.

I would say he was under the influence of a sedative or one of the pain-killing drugs, to the extent that I did not feel much could be served by talking to him, because he was not what I would say alert.

Q. The wound was bandaged?

A. Yes. [127]

Q. Did you look at that time at the wound or not? A. No.

Q. Did you ever look at the wound?

(Testimony of Dr. Lee A. Craig, Jr.)

A. No.

Q. Would you tell me whether there was any blood coming through the bandage?

A. I don't remember seeing any.

Q. Can you look at the record there that you have before you and see if it helps you in any way to refresh your memory?

A. June 10th, at 9:00 o'clock p.m., there is a nurse's note, "Some bleeding from left leg," which I assume was oozing through the dressing; and again on the 11th the bedside notes show "Some bleeding through dressing," so I assume that there was some oozing.

Q. Can you give us some idea of the size of the dressing surrounding the wound?

A. As I said, extended from above the knee down to the foot and it was quite bulky.

Q. Would it take an appreciable amount of blood to come through a dressing of that size?

A. Well, maybe half a teacup, if you have to estimate the amount. In any wound like this you get a great deal of serum that oozes out, which must be distinguished from fresh blood. You can have a larger volume of serum colored by a smaller [128] amount of red blood.

Q. Is there any significance to that oozing of serum?

A. That is usual in this type of injury.

Q. It is usual in this type of injury?

A. Yes.

Q. You are assuming from the information it was a compound fracture of the left tibia?

(Testimony of Dr. Lee A. Craig, Jr.)

A. Yes.

Q. Did you at this time look at the X-rays?

A. On the 11th?

Q. Yes.

A. I don't recall that I have an independent recollection, but normally I would.

Q. The X-rays were taken on the 10th, as you know, from looking at the record. Does that refresh your recollection at all, or do you just have to go on the basis that you normally would have looked at them?

A. Well, I would have to go on that basis.

Q. Did you take the patient's blood pressure?

A. I did not take it myself personally, no.

Q. Have you any idea what the blood pressure was at that time?

A. Are you speaking generally, during his stay in the hospital?

Q. Excuse me? [129]

A. Just generally throughout his stay in the hospital?

Q. Well, was it fairly constant during his stay at the hospital?

A. From what I have heard—hearsay—it was, yes, but let me look here. The two pressures I see are, one at 135 and one at 140. That is reasonably constant.

Q. If you were concerned about shock in the patient, would you take his blood pressure?

A. Yes, I think so. I would say this: We would check it at—to check it at too frequent intervals

(Testimony of Dr. Lee A. Craig, Jr.)
might be a needless waste of time; on the other hand, if the patient looked pale, it might be well to check it more often.

Q. Was this patient in a state of shock?

A. I would say he was in moderate shock, from what I was told.

Q. Would the fact that he was under sedation make difficult a diagnosis as to what his condition with relation to shock was? A. No.

Q. From your observation of the patient, not from what you were told, would you say the patient was in shock? A. No.

Q. You did not take his blood pressure at that time or at any time during the course of treatment there? Is that correct? [130]

A. No. Yes, that is correct.

Q. Anything else you observed about the patient when you saw him on the morning of the 11th?

A. No. I think I have described his condition pretty well. He was just simply lying in bed, and he was uncomfortable, as you might expect.

Q. Did you see the patient again, Doctor?

A. No, I don't recall that I did; no.

Q. Will you describe how the patient's leg was elevated in the bed?

A. Elevated on pillows, with the knee bent slightly, I would say.

Q. There was no external splint on the leg you could see?

A. I would say the dressing that was on the leg constituted a splint.

(Testimony of Dr. Lee A. Craig, Jr.)

Q. It constituted a splint? Did you see a common splint on the leg? A. No.

Q. Did you have a further consultation with Dr. Leonard regarding the patient on the 11th?

A. You mean separate from the consultation on the 10th?

Q. Yes. A. Yes, I believe I did.

Q. You had a conversation with him on the 10th?

A. Well, as I already told you, I am not sure whether I [131] talked to him or whether Dr. Schneider talked to him.

Q. Then, on the 11th, did you have a further conference? A. Yes.

Q. What was the nature of the conference that took place?

A. We discussed his general condition.

Q. What did the two of you talk about?

A. If he were stable enough to transport, would it be all right, you might say, to send him to Seattle. That, in essence, would be what we talked about. In other words, in the meantime, it had come up that he could be transported and we had decided his condition was perhaps suitable, and we would like Dr. Leonard's approval of that before we did the paper work involved.

Q. Did Dr. Leonard say he had looked at the wound? A. I don't recall that he did, no.

Q. Do you know if Dr. Leonard looked at the wound? A. Well, I doubt if he did.

Q. You say he was suitable to be transported. This was on the 11th. Was it during the morning

(Testimony of Dr. Lee A. Craig, Jr.)
of the 11th, about 11:00 o'clock, when Dr. Leonard was at the hospital, or would it have been later in the day that you conferred with him?

A. It would have been probably that afternoon.

Q. When you contemplated sending the man to Seattle, did you discuss what he needed treatment for? [132]

A. Well, in general, I think we all agreed the fracture should be reduced. This is my own thought. I don't recall the exact conversation, but the fracture should be reduced as completely as possible and a suitable splint applied and a plaster cast or traction if that becomes necessary. Many times you can't determine whether traction or a cast is necessary until you have actually tried to completely reduce the fracture.

Q. Did Dr. Leonard tell you what had been done to the wound by Dr. Schneider?

A. No, I don't think so.

Q. Did you tell Dr. Leondard what had been done to the wound by Dr. Schneider?

A. No, because I think he certainly would have already discussed this with Dr. Schneider or Dr. Stalder.

Q. Was there any discussion of the factor of time with regard to further treatment of the leg?

A. In order to arrive at a decision as to whether you were going to send him, you had to agree that the time that it took to transfer him would be time that would not be harmful to him, so I think we did consider the time factor.

(Testimony of Dr. Lee A. Craig, Jr.)

Q. Was there any discussion that the critical time had already passed by the time you and Leonard had your conversation as to the treatment of this leg?

A. You say "critical time." What do you mean by that? [133]

Q. I am assuming that the man was brought in at 1:15 on the afternoon of the 10th and you had this conversation with Dr. Leonard sometime after 11:00 o'clock on the 11th. A. Yes.

Q. Was there any discussion that there had been any lost opportunity in regard to treatment?

A. No. As a matter of fact, I think we were all glad that time had elapsed simply because it allowed the patient to go through this period of instability rather than a period in which shock would be likely to ensue.

Q. If there had been a debridement, a closing of the wound, would it have to be done in general surgery as distinguished from the emergency room?

A. I think the nature of the wound would determine whether the man required general surgery or not. If it were a large procedure involved, trimming of dead or devitalized tissue, it might require major surgery, or the need of surgery, but I think, from what I know about this particular wound, it didn't require that type of debridement.

The Court: Adjourn until 10:00 o'clock tomorrow.

(Thereupon an adjournment was taken until 10:00 o'clock a.m. Thursday, July 22, [134] 1954.)

Thursday, July 22, 1954

(Court reconvened at 10:00 o'clock a.m., pursuant to adjournment, and further proceedings herein were resumed as follows:)

Mr. John D. Ryan: If the Court please, there may be some problem in obtaining the last witness to be called by the plaintiff this morning, Dr. Cherry, and counsel for the defendant have asked if one of their witnesses might be put on out of order at this time.

The Court: I don't care about the order.

Mr. Luckey: We are not interested in putting on any testimony out of order. If the plaintiff can complete his case, I don't want to put on any evidence which would prejudice our rights to make a proper motion at the end of the plaintiff's case in chief.

The Court: I understand.

Mr. Luckey: If Counsel wants to stipulate it will be without prejudice——

The Court: He does not need to stipulate. I will make that decision.

Mr. John D. Ryan: It is certainly agreeable with us.

Mr. Harr: This witness will be a very short one. He is the ambulance driver who took the plaintiff to the hospital.

The Court: Put on your evidence in any order you want to. It does not make any difference to me. [135]

ROY COX

produced as a witness on behalf of the Defendant, United States of America, out of order, being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Harr:

Q. Will you please state your full name?

A. Roy Cox.

Q. George? A. Roy.

Q. What is your occupation?

A. Ambulance driver.

Q. You work for the Buck Ambulance Company now? A. Yes.

Q. On June 10, 1952, what was your occupation?

A. I was an ambulance driver.

Q. That was for the Arrow Ambulance Company at that time? A. Yes.

Q. On June 12, 1952, did you go to the Physicians and Surgeons Hospital in Portland, Oregon, and pick up two patients to take to Seattle?

A. Yes, sir; I did.

Q. Was one of those patients Amos Morin?

A. Yes.

Q. You then transported these two patients to Seattle? A. Yes. [136]

Q. To what hospital in Seattle?

A. U. S. Marine Hospital.

Q. That is the U. S. Public Health Service Hospital in Seattle? A. Yes.

Q. Do you know what time you went to the

(Testimony of Roy Cox.)

hospital, the Physicians and Surgeons Hospital, in Portland, to get these patients?

A. Well, it was just about 8:00 o'clock when I arrived there.

Q. Then did you take the patients aboard promptly?

A. Yes, we loaded the two patients and left for Seattle immediately.

Q. What, if anything, was given to you to deliver to the hospital authorities in Seattle?

A. There was an envelope for each patient given to us at the P & S, and we delivered them to the admission office at the Seattle hospital.

Q. That was from the U. S. Public Health Service at Portland addressed to the U. S. Public Health Service at Seattle? A. Yes.

Q. Did you have sealed envelopes, or were they sealed envelopes, do you remember?

A. To the best of my knowledge, they were sealed, yes.

Q. Did you deliver those envelopes in Seattle when you [137] arrived there at the hospital?

A. Yes.

Q. In transporting these two patients to Seattle, on your route up there, you by-passed Tacoma and Olympia, did you not? You turned off at Tenino?

A. Well, I don't remember if we turned off at Tenino.

Q. Do you know about what time you arrived in Seattle?

A. It was probably a little after 12:00. I don't know exactly.

(Testimony of Roy Cox.)

Q. What was the nature of the vehicle you were driving? A. It was a '52 Cadillac.

Q. Do you know how the berths were arranged in there? What was the arrangement?

A. A cot along each side of the ambulance and there are two arms that go up on each side.

Q. Sort of rails that fit close to the individual?

A. Yes, right close, about like that (illustrating).

Q. In other words, were those rails to prevent a person from moving about?

A. So you couldn't roll off the cot.

Q. Do you recall whether or not there was anything put under the back of Mr. Morin at the time he left the Physicians and Surgeons Hospital?

A. Well, I think—I know we had him laying real flat. I think they wanted us to have a little pillow or something right [138] under his back, if I remember.

The Court: I need to have something cleared up. Is complaint being made about the back?

Mr. John D. Ryan: No, your Honor, just the leg.

Mr. Harr: Except the back was one of the conditions that we had to contend with; that is all.

The Court: Proceed.

Q. (By Mr. Harr): Do you know whether or not there were any sedatives taken along, or empirin?

A. I think there was some empirin taken along, in back of the ambulance. I don't know whether the attendant gave him that empirin or not.

(Testimony of Roy Cox.)

Q. There was an attendant in the back at all times? A. Yes.

Q. From the time you left Portland until you arrived in Seattle? A. Yes.

Q. Do you know anything about Mr. Morin's condition during that trip?

A. Well, several times along the road I asked the attendant how the patients were riding, and no one complained to me.

Q. Do you know whether or not Mr. Morin slept throughout the greater part of the trip?

A. I think he slept quite a bit. I don't know how much.

Mr. Harr: That is all. [139]

Cross-Examination

By Mr. John D. Ryan:

Q. Do you recall this case of your own personal knowledge, or has your knowledge been refreshed?

A. Yes, I recall it, because we didn't have to make too many trips up there.

Q. You rode in the front seat of the ambulance at all times? A. Yes.

Q. Had you reason to observe the leg of Mr. Morin?

A. I don't recall too much about his leg. I know he had some injuries, you know.

Q. Were you given any particular instructions?

A. Well, just to keep him flat. We had orders

(Testimony of Roy Cox.)

to take these—you know, to deliver the papers. I presume there were orders as to him.

Q. Who gave you your instructions?

A. The nurse—I don't know which nurse it was —at the Physicians and Surgeons, but the nurse on the floor. I think, if I remember right, she had me go to the admitting office and pick them up. They leave the envelopes there at the office. That is where we generally pick them up, you know.

Mr. John D. Ryan: I have no further questions.

Mr. Harr: I think that is all.

(Witness excused.) [140]

DR. LEE A. CRAIG, JR.

a witness produced in behalf of the plaintiff, having been previously duly sworn, resumed the stand and further testified as follows:

Direct Examination
(Continued)

By Mr. John D. Ryan:

Mr. John D. Ryan: I believe Dr. Craig was being handed Plaintiff's Exhibit No. 3 at the close of the session yesterday.

Q. Would you look at the summary in Plaintiff's Exhibit No. 3, which is the clinical record of treatment of the U. S. Marine Hospital of the plaintiff. Are you familiar with the description of the wound as it is given in that summary, Doctor?

A. Not exactly.

(Testimony of Lee A. Craig, Jr.)

Q. Would you just read the description of the wound as it is given there? Read it out loud?

A. "On admission, the patient immediately underwent scrubbing of the leg and irrigation of the wound."

Q. The description, I believe, is above that, isn't it, Doctor?

A. Yes. May I read that portion?

Q. Yes, just read the description of the condition of the wound.

A. "There was laceration approximately a [141] 12 cm. long and 4 cm. wide over the anterior midshin, left, with proximal bone fragment out through the wound. There was considerable dried blood around laceration with rather strong odor but no gross infection noted."

Q. In a wound of that kind would you say early reduction would be advised?

A. I don't know that that in itself constitutes an indication for early or late reduction of the fracture.

Mr. Harr: If your Honor please, at this time I do not think there has been any testimony establishing that there was such a wound with a laceration of that proportion. It is true that it shows in this particular exhibit, but I think the record other than that and the evidence will completely refute that; that that is hearsay; and that to question the witness now as to a wound of that type, that proportion, a laceration four or five inches long, I do not think is proper.

The Court: Proceed.

(Testimony of Lee A. Craig, Jr.)

Q. (By Mr. John D. Ryan): Doctor, would you answer that last question?

(Question read.)

Q. In a compound fracture of the lower third of the left tibia, would you say that early reduction is advisable?

A. I think that is a surgical or orthopedic [142] question.

Q. In your deposition, Doctor, you said you did feel early reduction is always advisable. Could you tell why you made that statement in your deposition?

A. I was speaking of fractures in general and not necessarily this particular one, or even this particular type of leg injury.

Q. Would you tell us why fractures in general should have early reduction?

A. Just simply this: It produces a situation in which healing can go right ahead and it can heal, particularly small fractures where there is not a great deal of injury otherwise to the patient, you would perhaps reduce the fracture on the spot.

Q. In a compound fracture what is particularly dangerous—what is it you need for an early reduction?

A. I think that takes us in the technical area of discussion. I do not think I am qualified to answer the question, at least to say in the light of this particular fracture.

(Testimony of Lee A. Craig, Jr.)

Q. Are you saying early reduction is not advised in a fracture of this type?

A. It may be in some fractures of this type.

Mr. Luckey: We have a situation here, your Honor, in which a man is brought to a hospital with an injured back, and the possibility of shock is indicated. Then, in addition, he has a compound fracture to the leg. I think if Counsel [143] wants to elicit this information from the witness he should frame a proper question based on all of the facts in the case, not just on some.

The Court: All expert testimony is very unsatisfactory, as far as I am concerned. This gentleman has handled himself quite well. When a question is asked that he feels he is not competent to answer, he can say so.

Hurry along, gentlemen. You are dragging this case out too far.

Mr. John D. Ryan: Your Honor, I have no further questions in this field. I am not certain whether this man was subpoenaed to testify as an adverse witness. I have no further inquiries at this time.

Mr. Harr: I suppose your Honor will determine in your own mind whether or not he is a so-called expert witness, or is adverse.

The Court: You will have to guess what is in my mind, Mr. Harr.

(Testimony of Lee A. Craig, Jr.)

Cross-Examination

By Mr. Harr:

Q. Earlier in your testimony you were questioned about the use of orthopedic specialists in special cases, and you developed the fact you could call Dr. Kimberley. You developed further that you had other specialists in other [144] fields that were available for calls, in case you felt the need. Was Dr. Kimberley or were any of these specialists on salary, full or part-time? A. No.

Q. They were strictly on a fee basis, and would be paid when and if called for the time that they devoted, is that not true? A. Yes.

Q. On direct examination emphasis was laid upon the fact of the fractured leg, and there was little, if any, discussion of the back.

I think at one point you said that the leg—that the thing that needed to be done with the leg was to reduce the fracture and put it in a cast. You made that as a general statement as the thing to be done.

Did you also have in mind the back condition, and think that of necessity something would have to be done to the back?

A. I don't think we discussed the back as such. I don't think we insisted that the back be placed in a cast, no.

Q. What injuries at that early stage did you consider to be the most serious?

A. During the period of the first 24 hours I

(Testimony of Lee A. Craig, Jr.)
would say the back injury produced symptoms that were more serious than perhaps his leg injury. [145]

Q. You knew, of course, the fact that an ileus did result? A. Yes.

Q. And was treated? A. Yes.

Q. You made your rounds of the hospital in the morning, is that right? A. That is right.

Q. What about other periods during the day? If anything developed where a patient's condition had deteriorated, what was the practice?

A. The practice would be that the patient would be checked either by Dr. Stalder or Dr. Schneider, one of the residents at the hospital, and we would be called at the office, just as any physician would.

Q. Is that the general practice with your office and also with all doctors generally? Is that not true? A. Yes.

Q. You are a member of the Multnomah County Medical Society, are you not? A. Yes.

Q. And you were at the time of this accident?

A. No, I was not then.

Q. And you received no such calls on either the afternoon of the 10th or the 11th, is that correct?

A. Other than the call from Dr. Schneider there initially, [146] on the 10th, I did not receive any further calls either that evening or that next day, no.

Q. Therefore, you had a right to assume that the patient was progressing satisfactorily?

A. Yes.

Q. At the time you visited him on the morning of

(Testimony of Lee A. Craig, Jr.)

June 11th, did the records and charts and X-rays at the time indicate to you that there was any other treatment that he should be given other than what Dr. Schneider had previously ordered?

A. No, not at that time.

Q. I assume you did check the charts and X-rays? A. Yes.

Q. And you were satisfied with the orders as given? A. Yes.

Q. Counsel asked you whether or not you looked at the wound. Since he was put in there and was going through this course of treatment to alleviate his pain and stop the ileus condition, would it have been advisable to have opened the wound, opened the bandage and looked at the wound, from the information Dr. Schneider gave you and from what the chart showed?

A. No, I think it would have been harmful.

Q. In the first place, it would have removed the immobilization that had been planned, is that not right? A. Yes.

Q. And, further, I suppose it would have exposed it to [147] further contamination of the air, is that right?

A. Possible infection, yes.

Mr. Harr: I think that is all.

Mr. John D. Ryan: No further questions.

(Witness excused.) [148]

AMOS R. MORIN

the Plaintiff herein, produced as a witness on his own behalf, being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. John D. Ryan:

Q. You are Amos R. Morin, the plaintiff in this case? A. Yes.

Q. How old are you? A. 45.

Q. What is your employment?

A. I work for the U. S. Engineers on the Dredge Wahkiakum.

Q. What is your job down there?

A. I am Third Mate.

Q. How many children have you?

A. I have six.

Q. You are married and your wife has testified here before? A. Yes, sir.

Q. Where do you live?

A. 4640 Northeast 30.

Q. How long have you been working with the U. S. Engineers? A. Six years.

Q. Was that in one period of service?

A. I had served in the Navy twice. I got my ten-year pin when I was up in the Seattle hospital.

Q. What sort of duties did you perform in the Navy? [149]

A. My first hitch that I put in, I was a musician; the second hitch I put in during the last war, that was in underwater explosives.

(Testimony of Amos R. Morin.)

Q. Since your Navy training, you have worked with the U. S. Engineers, is that right?

A. Yes.

Q. Previous to your Navy work, what type of employment had you had?

A. I worked in mines in Colorado and Utah and Nevada, hard rock mines.

Q. What kind of mining?

A. Hard rock mining.

Q. Would you give us some idea of your duties as Third Mate on the Dredge Wahkiakum?

A. Well, we walk the floating plant when we are digging to see that everything goes right, and walk the pipe line, and run the machinery, and whatever comes up.

Q. Could you tell us about how far you fell at the time you fell on June 10, 1952?

A. Well, I fell about 10 feet, I think it was. You could see the track of the ladder where it slipped out down the side of the house. I measured it afterwards, and it was just at 10 feet.

Q. This was at your house in Portland where you had just fallen? [150] A. Yes.

Q. Tell what happened when you fell?

A. I was up there, painting underneath the eaves of our house, and the windows—well, earlier in the morning, just about an hour before I fell, it became a little showery, so I got down from the ladder and went in the house and got a cup of coffee and went back out to paint, climbed up the ladder, and was up the ladder when I noticed that the ladder had

(Testimony of Amos R. Morin.)

slipped out, it looked to be about 4 inches. I just glanced down at the bottom of it and thought I had better go down and fix it.

I started down and just took one step when the bottom of the ladder kicked out and my leg went through the rungs of the ladder—it all happened so quick.

Q. When you fell to the ground, what happened?

A. I fell in a sitting position and my leg was through the rungs of the ladder, and a rung was across my shin-bone, and I knew as soon as I lit that that leg was broke, because I heard it snap; you could just hear it, so I called for the boys and I rolled over on my side. They lifted up the ladder and I pulled my leg out and then I looked at my leg.

Q. What did you see?

A. I seen the bone sticking out. It looked bad to me—about an inch or an inch and a half.

Q. Was there blood down there? [151]

A. Yes, it was bleeding pretty bad.

Q. You were fully conscious, I take it, from what you are saying? A. Yes.

Q. Where was your body? Was it on the grass or sidewalk, or how was it lying?

A. I think my—I think I stepped right on the edge of the sidewalk and then when I laid back—it is only about a two-and-a-half-foot sidewalk—it put my head right in the edge of the flower bed.

Q. Do you recall the doctor coming out there?

A. Yes.

(Testimony of Amos R. Morin.)

Q. Who was that? A. Dr. Done.

Q. What did he do for you?

A. He gave me a shot of something. I guess it was a sedative; I couldn't say; and he put a tape on my forehead.

Q. Can you tell us or show us on the left leg where the bone protruded, which side of your leg?

A. It is on the left side.

Q. Is there a scar there where you are pointing?

A. Yes.

Q. You are pointing to your left leg. Would you pull your pants leg up? A. Yes. [152]

Q. You are pointing to your left leg, on the outside of your left leg and running up to the top of it?

A. Yes.

Q. How long is that scar?

A. I would say three inches.

Q. Is that the place where you recall the end of that bone sticking out? A. Yes.

Q. Is that the scar there? A. Yes.

Q. Tell us where the cut was or where the surgery was done? A. Here (indicating).

Q. The scar you are pointing out now?

A. Yes.

Q. Do you recall what next happened to you? Were you taken to the Physicians and Surgeons Hospital?

A. Yes. I only had my young boys there, but I tried to direct them in what should be done. I told them—one of them should go and get a doctor and the other one should get a blanket for me to cover

(Testimony of Amos R. Morin.)

myself up with, any my daughter came up then and I told her to get hold of an ambulance. They asked me where I wanted to go, because I had Blue Cross and I was a veteran, and I also was insured through the Public Health Service at Physicians and Surgeons Hospital, so I told [153] them to take me to Physicians and Surgeons Hospital. They were surprised that that is where I was going.

Q. Do you have any idea how long it was before the ambulance picked you up?

A. No, I don't. It seemed like it was about 15 minutes, but I couldn't say.

Q. Could you tell us when this accident took place?

A. Just a little after dinner time, a little after noon.

Q. Dinner time is noon to you? A. Yes.

Q. You were taken by ambulance, then?

A. Yes.

Q. Were you conscious when in the ambulance?

A. Yes.

Q. Could you feel the effects of the ride at all?

A. No, not too much, but I kept telling the ambulance driver, or the attendant, to please hold my leg—the man who was riding in back. It seemed like it would bounce off the table or bed that I was in.

Q. Were you in pain? A. Very much.

Q. Were you pain both in your back and leg?

A. Mostly in my leg.

Q. When you got to the Physicians and Sur-

(Testimony of Amos R. Morin.)

geons Hospital, can you tell us what you remember about what happened to you [154] there?

A. Well, I can tell you as far as I remember. I went in there. I remember going into the emergency room. They put me up there on the table in the first-aid room and pulled up my trousers—I don't know which doctor it was. I don't recall—I never seen him before or since—and he says, "Mr. Morin, we are going to have to cut your trousers off."

I said, "Go ahead and cut them off, but please hold my leg. It is just about to bounce off the table." So that is the end of my recollection.

Q. That is all you remember? A. Yes.

Q. Did you pass out just from shock, or were you given further sedation?

A. I was given further sedation, and my back was pretty bad then.

Q. That is all you recollect, then, on June 10, 1952, is that right? A. Yes.

Q. Prior to passing out? A. Yes.

Q. After the time you saw your leg when lying on the ground after you fell, did you have reason to look at your wound or your leg again?

A. Yes, I looked at it the second time when I was in the [155] ambulance. It seemed like it took the ambulance quite a while to get there; it seemed long to me, anyway, and I looked at my leg again.

Q. What did you see that second time?

A. I seen for sure that bone was sticking out—a compound fracture, and the bone was protruding.

Q. When you say "compound fracture," did you

(Testimony of Amos R. Morin.)

know what a compound fracture was at that time?

A. Yes.

Q. How did you happen to know that?

A. I hold a first-aid card, an advanced first-aid card.

Q. You were aware of what was the matter with you? A. Yes.

Q. After you passed out in the emergency room, can you tell us what you next remember about your treatment?

A. Nothing, sir. I don't remember nothing. Sunday evening I got up—I woke up and found myself in Seattle. That was my next recollection.

Q. That is Sunday evening, June 15, 1952?

A. Yes.

Q. Do you recall anybody talking to you after you passed out in Physicians and Surgeons Hospital in Portland? A. No.

Q. Would you tell us what your general condition was when you woke up on June 15, 1952? [156]

A. Well, I was a pretty sick boy and the orderly was in there and he says, "Boy, you had better get some liquids down you," and the wife was there and she kept pouring liquids down. It was all still hazy Sunday evening. I don't remember too much. I did recognize my wife and my oldest daughter who had come up there to see me.

Q. Were you in a cast?

A. Yes, I was in a full body cast and a full leg cast.

Q. Were you aware of any pain in your leg?

(Testimony of Amos R. Morin.)

A. Yes, sir. I told my wife that Sunday evening —it was either that Sunday evening or the next Monday morning when she came in—I think it was on Sunday evening—that my leg wasn't set; it was still wriggling around.

Q. Was your back in a body cast?

A. Yes, it was in a body cast.

Q. Did you have reason to observe your arms or your head?

A. My arms was bruised and the top of my head was all skinned up, around my neck.

Q. After this, could you tell us what took place at the hospital? Did you remain in bed?

A. The next morning—that would be Monday morning—Dr. Brown came in to see me, and he was the doctor I was turned over to when I got there in the ward—I was in a private room, and he came in in the morning, and he said, "Well, I see you are awake," and he said, "What kind of [157] doctors have you got down there in Portland, to send a man up here in your condition"? And that is all he said. I didn't feel like talking either, but that morning I did tell him that I didn't believe my leg was set, that I felt like it was still moving around, and he said, "Well, we will check that."

Q. The record shows that you had a further operation on July 13, 1952, up there in the hospital?

A. Yes.

Q. Did they tell you what they had done to you when you came into the hospital, the United States Marine Hospital?

(Testimony of Amos R. Morin.)

A. Please explain that again.

Q. Did anybody tell you what was done to you when you were brought into the Marine Hospital on June 12, 1952? A. No.

Q. Between June 12, 1952, and July 13, 1952, did the hospital give you any further treatment to your leg directly?

The Court: June and July?

Mr. John D. Ryan: Excuse me, your Honor. It was between June 12, 1952, and July 13, 1952.

The Court: July?

Mr. John D. Ryan: Yes, your Honor. I believe the record shows that on July 13, 1952, this gentleman had a further operation at the U. S. Marine Hospital.

The Court: When did he have this talk with Dr. Brown? [158]

Q. (By Mr. John D. Ryan): When did you have this talk with Dr. Brown?

A. It was on the Monday morning after I got in there.

Q. After you got there? A. Yes.

The Court: In June?

Q. (By Mr. John D. Ryan): In June?

A. Yes.

Q. That would be June 16, I believe, 1952?

A. Yes.

Q. After that the cast remained on your leg?

A. Yes.

Q. Did they do anything to the cast?

(Testimony of Amos R. Morin.)

A. They cut a window in it. I think I was scheduled—I don't know for sure, but I think I was scheduled for an operation on a Wednesday before the Friday that I was operated on, and they cut a window in there on a Monday, Monday morning—I don't remember the date.

The Court: Are you talking about July, now?

The Witness: July.

Q. (By Mr. John D. Ryan): You are talking about July? A. Yes.

Mr. John D. Ryan: I just want to clarify this for your Honor.

The Court: I understand now. It was in [159] July.

Mr. John D. Ryan: Yes.

A. They cut a window on a Monday, and the bones wasn't set; they was up on top of one another, and they said I would have to go back—they took my body cast off, and I think it was that Monday when they cut the window in my leg cast. I told the doctor—I don't know whether it was Dr. King or who the doctor was—it seemed to me like it was a little short, heavy-set fellow that had my case before Dr. King got there. They took my body cast off, and there wasn't any pain, it didn't hurt. I said to whoever the doctor was—I don't remember whether it was Dr. King or who it was. I said, "We don't have to put another one on, do we"? And he said, "No, I don't think you are going to have to have one."

They took me up Friday and when I woke up out

(Testimony of Amos R. Morin.)

of that, I had another body cast on and another leg cast, and after that he told me that they had to put a plate, an Egger's plate, and a bone graft in my leg, at the time they cut this window in that cast.

Q. You say there was no pain. Are you referring to your back or leg? A. My back.

Q. What was the condition of your leg at that time? A. It was hurting.

Q. Will you describe the effect of the pain? [160]

A. It was a throbbing pain. It just seemed that it was throbbing all the time. They kept me under pretty heavy anesthetic all the time.

Q. Were you pretty doped up all the time you were there? A. Yes.

Q. When they cut this window in the cast, did they give any treatment to the bone part of the wound? A. I don't know.

Q. Did they give you any information regarding your condition at that time? A. No.

Q. That would be July 13, 1952?

A. Yes.

Mr. Harr: This line of testimony I suppose is directed to the history of the case. There is no contention made of any wrongdoing in the Seattle hospital.

The Witness: That is right, sir.

Mr. Harr: As the pre-trial order sets forth, the entire claim is predicated on the wrong treatment, if any, during the 40 hours he was in Physicians and Surgeons Hospital in Portland. This is just the history you are developing now?

(Testimony of Amos R. Morin.)

Mr. John D. Ryan: The purpose of this questioning, of course, is to fully develop and show the subsequent course of the man's condition in order to relate it to what we contend was improper treatment in Portland. [161]

Q. After the operation, which was on July 13, 1952, or thereabouts, what was your condition?

A. It wasn't good.

Q. Did you have a cast on your leg when you came down from surgery? A. Yes.

Q. Would you describe what happened after that, as far as the cast on your leg was concerned?

A. I came out of my anesthesia, I think it was, Saturday evening, and my leg was hurting terribly bad. It was all bloody and soaked through, and I asked the nurse Sunday morning if she would get Dr. Walker for me.

Dr. Walker came up Sunday afternoon and cut my cast open, and rebound my leg and taped the cast back on.

Q. After that did you keep that cast on, or what?

A. No, I think they took me up, if I remember right—they took me up and put another cast on the following week.

Q. Would you describe for us what happened to you, as far as your treatment was concerned?

A. They kept me in that cast for, I think, about a week, if I remember right. Then they cut a window out. It was hurting pretty bad, so they cut a window in there where they had put the plate, and it just

(Testimony of Amos R. Morin.)

started splitting, and they couldn't hold it. It seems like they wasn't getting anywhere with it. [162]

Q. Did they discuss this condition with you?

A. Yes, Dr. King came in there and I asked him, "How about me going back down and going in the Veterans Hospital or going in some other hospital where I can get an orthopedic specialist on the leg?" And he said, "Well, we can see about it," so he did send me out to the V. A. man from Seattle and the V. A. man from Seattle said they didn't have room because the hospital wasn't finished yet—the V. A. Hospital wasn't finished up there as yet—and he said if I could pay my way back down the V. A. in Portland district would—I could more than likely get in down here, so I decided that is the time I should leave up there, because I wasn't getting anywhere up there.

Q. You were able to pay your way back? You had sufficient funds?

A. Yes. I was in a full body cast and a full leg cast.

Q. When they cut this window in the cast on your leg, about how long after the Egger's plate was put in was that done?

A. Not quite a week.

Q. Did they leave a window in the cast?

A. Yes.

Q. Did they give you any treatment?

A. Yes, I was always getting penicillin or whatever it is, some antibiotic or whatever it is.

Q. Was there any possibility for you to see the site of your [163] wound?

(Testimony of Amos R. Morin.)

A. Oh, yes. I could look at it.

Q. What was its condition at that time?

A. It looked pretty rough to me. It looked pretty rough to Dr. King, too. I think he will say the same thing.

Q. Did he tell you anything about it?

A. He said——

Q. What did he tell you?

A. He said if this don't improve pretty soon there would be a chance that it might have to be amputated.

Q. Did he say the leg was infected?

A. Yes.

Q. That conversation took place about a week after the operation?

A. About a week or ten days after the operation.

Q. At this time what was the condition of your back?

A. My back was all right, but it was still in a cast. They had it in a cast.

Q. Were you able to get up out of bed at any time?

A. I got up on one of these things they call a Gunner's cart, a four-wheel cart is what it is.

Q. Did you continue to have the window cut in your cast, or did they change the cast after the window was cut?

A. No, I don't think there was a change made in the cast any more. [164]

Q. According to your recollection, sometime, a

(Testimony of Amos R. Morin.)

week or ten days, after the operation of July 13, 1952, you had a window cut in your cast?

A. Yes.

Q. Did they treat you with hot packs?

A. Yes, hot packs.

Q. How often would they treat you with those hot packs? A. Three times a day.

Q. Did they continue those during the duration of your stay at the hospital? A. Yes.

Q. Did you see any pus coming out of the wound? A. Yes.

Q. When did you see that?

A. When they first opened it up, when they first cut that window in and they got busy with the hot packs.

Q. What was the condition of your leg with regard to pain? A. Oh, it hurt.

Q. Can you tell us what kind of pain it was?

A. It was a throbbing pain.

Q. Is that the same pain you had had all the time? A. Yes, all the time.

Q. Was there any sloughing of the skin itself around the wound?

A. No. There was quite a bit of scar tissue around there. [165]

Q. You said the wound was splitting, if I understood you?

A. That is the wound down the side of my leg.

Q. Was that the wound where the incision was made or the wound where the bone went out?

A. The wound where the incision was made.

(Testimony of Amos R. Morin.)

Q. There were two separate wounds on your leg, in other words? A. Yes.

Q. Would you show us the wound where the incision was made? A. (Indicating.)

Q. That is approximately about a foot long?

A. Yes.

Q. That is on the inside of your leg, your left leg, is that correct? A. Yes.

Q. The other one we are discussing is the wound where the bone protruded? A. Yes.

Q. You have already shown that?

A. Yes.

Q. Was there any sloughing of the skin there?

A. Yes.

Q. You said Dr. King discussed the possibility that there might be an amputation? [166]

A. Yes; one morning when I was talking to him in there, and he said, "Boy, if you don't straighten up, we are going to have to cut that thing off; that is one thing for sure."

Q. You were able to be up in this cart you spoke of? A. Yes.

Q. Were you ever up in a wheelchair?

A. No, I couldn't sit up. I was in two casts, one on my back and my leg, and I couldn't sit down, so I rolled out of bed on this cart and that was my transportation.

Q. Pardon?

A. That was my transportation when I got out of bed.

(Testimony of Amos R. Morin.)

Q. You were in the hospital there until what date? A. August 13th.

Q. Would you tell us why you left the hospital?

A. I felt I could get better care with an orthopedic doctor down here in Portland, and also be near my family.

Q. Were you concerned about your condition?

A. Yes, I was.

Q. Did you have any discussion about your condition at the time you left there?

A. I told Dr. King I was going to leave and he said, "Well, Boy, we couldn't hold you. We can't give you our permission." It wasn't Dr. King; it was whatever person I discussed leaving with, a dark-headed fellow that came there after Dr. King had.

Q. All during this time you had a window in your cast and [167] you were getting hot packs applied? A. Yes.

Q. You left there August 13, 1952, I think the record shows? A. Yes.

Q. At the time you left was anything done to your cast? A. No.

Q. Was the window replaced in it?

A. It was in place, sealed in with tape.

Q. Had it been in place prior to your leaving?

A. They took it out when they put the hot packs on and then put it back in again.

Q. When you left the hospital, the window was back in? A. Yes.

(Testimony of Amos R. Morin.)

Q. Did you receive penicillin up to the time you left? A. Yes.

Q. Or some kind of antibiotics?

A. Some; I don't know what it was.

Q. Tell us how you came down to Portland?

A. Came down in our car.

Q. With your wife?

A. My wife was driving.

Q. When you got to Portland, what date was that? The 13th?

A. It was the 14th, I think—the 13th, when I got to Portland, yes, early afternoon. [168]

Q. Did you seek medical care when you got to Portland? A. Yes, the next day.

Q. Whom did you see?

A. Dr. Thorup.

Q. What did he do?

A. He started giving me penicillin, and the following day he said, "We will come up and help you up to the office so I can get X-rays." So I went down to his office on a Thursday and he had X-rays taken of my leg and also of my back.

Q. Up until this time did the cast remain sealed where the window was?

A. Yes. He opened the window at the office.

Q. I am speaking about up to the time you went to his office? A. Yes.

Q. Did he first call at your home on the 14th?

A. Yes. He opened the window and looked at my leg that day.

Q. What then did he do?

(Testimony of Amos R. Morin.)

A. He said, "We are going to have to get you a specialist. I will get in touch with Dr. Cherry and we will turn you over to him."

Q. Did he change your cast at that time?

A. They took my cast off, and took a picture of it and then put another cast immediately back on, the very same day. [169]

Q. Was that done in his office?

A. In his office.

Q. During the next few days did you continue to get treatments?

A. Every day, the nurse gave me the penicillin.

Q. And the nurse continued to give you the penicillin? A. Yes.

Q. How many times a day?

A. Twice a day.

Q. Your leg was in a cast after you left Dr. Thorup's office after the X-rays were taken?

A. Yes.

Q. How soon was it you went to the hospital again? A. The evening of the 23rd.

Q. Did Dr. Thorup make arrangements with you for you to go to the hospital? A. Yes.

Q. When did you first see Dr. Cherry?

A. The morning of the 24th.

Q. What happened to you there? What did they do?

A. They put me under anesthesia the next morning and when I woke up I had a different cast on my leg, and when Dr. Cherry came in he said they

(Testimony of Amos R. Morin.)

had to reset my leg under pressure. I didn't question his ability at all.

Q. That was in Providence Hospital? [170]

A. Yes, Providence Hospital.

Q. Did you remain in Providence Hospital for any length of time?

A. Yes, I stayed there for about two weeks. I think that was what it was.

Q. You had a cast on your leg after the reduction? A. Yes.

Q. Then what took place when you left Providence Hospital?

A. When I left Providence and came home, then I would go back about every two weeks as an outpatient to get—well, I went back in about two weeks and it was running, sloughing or running through my cast, and I went there to see him, to see Dr. Cherry, so he said, "Well, I guess we are going to have to take that plate out," so I went back in the hospital again and they removed the plate.

Q. When was that done?

A. Oh, I don't remember the exact date.

Q. There were a number of cast changes made?

A. Yes.

Q. There was sloughing coming through the cast? A. Yes.

Q. Were you able to work during this period?

A. I went to work as a watchman over at the yard. The boss gave me a job over there as a watchman. There was just a little walking in it, and Dr. Cherry said it might not hurt, [171] and I am a poor man and I needed the work, so I went to work.

(Testimony of Amos R. Morin.)

Q. In this period that we have been talking about, how did your leg feel?

A. It hurt all the time.

Q. Could you describe the condition? Was it draining?

A. Yes, it was draining all the time.

Q. Did the throbbing continue? A. Yes.

Q. Was that the general condition of the leg during this period? A. Yes.

(Recess.)

Q. We were talking about the treatment after the first reduction in August, 1952. Did you have any further treatment?

A. Yes. I went back to work on December 8th, 1952, and I worked until January 23, 1953, and I went back in the hospital on the 25th, I think it was, for further treatment, and they removed the plate from my leg.

Q. That is the 25th of January, 1953?

A. The 26th, I think it was.

Q. It was around in that period of time?

A. Yes.

Q. This work you were doing in the meantime was as a watchman? [172] A. Yes.

Q. You drew your usual rate of pay for doing that?

A. Yes, through the kindness of the boys out there where I worked.

Q. You were in Providence Hospital this next

(Testimony of Amos R. Morin.)

time for a straight period of how many weeks after your operation in January, 1953?

A. About three weeks, I think.

Q. After that were you able to return to work?

A. I returned to work later on July 20, 1953.

Q. On all of these occasions did you have a cast on? A. Yes.

Q. Except when being treated in the hospital?

A. Yes.

Q. You did not go back to work until July 20, 1953, after your operation in January and February, 1953——

A. I went back to work, I see here, February 24, 1953, and worked until April 12—no, April 26, 1953.

Q. What then took place? Did you have to have further hospitalization?

A. I had to have further hospitalization for an infection.

Q. Where did you go? A. St. Vincent's.

Q. Under whose care there?

A. Dr. Cherry's. [173]

Q. You continued to be under Dr. Cherry's treatment? A. Yes.

Q. What took place at St. Vincent's?

A. They used some kind of heat and light; I don't know what it was. I had full trust in Dr. Cherry.

Q. Did you have your cast removed up there while you received this treatment? A. Yes.

(Testimony of Amos R. Morin.)

Q. What was the condition of your leg at that time?

A. It was infected pretty bad.

Q. Was it draining? A. Yes.

Q. Was there pus? A. Yes.

Q. Was there an open wound? A. Yes.

Q. After your term at St. Vincent's, what then took place?

A. I came home for a while and then I went to the Veterans Hospital.

Q. When in a cast? A. Yes.

Q. Were you in a cast when you came home?

A. Yes.

Q. Was the wound covered by the cast?

A. Yes. It had a window in it. [174]

Q. Had a window? A. Yes.

Q. Did you continue to see Dr. Cherry for treatment? A. Yes.

Q. How often would you see him?

A. About twice a week, I think it was, maybe once a week.

Q. What was the condition of your leg with reference to pain at this time?

A. It hurt terribly bad.

Q. Who advised you to go to the Veterans Hospital? A. Dr. Cherry.

Q. What was the nature of his advice regarding that?

A. Well, I run out of my Blue Cross insurance; I didn't have any money; I was a veteran and I

(Testimony of Amos R. Morin.)

could go there, and he said, "Your best bet is up there."

Q. Were you treated by one of Dr. Cherry's colleagues? A. Yes, Dr. Davis.

Q. Did Dr. Cherry continue to see you?

A. Yes, he came up to the hospital and seen me at least for a couple of weeks.

Q. At the Veterans Hospital? A. Yes.

Q. When you went to the Veterans Hospital, what was done to you there?

A. Oh, on the first operation they went in there and they [175] scraped the bone and they debrided it.

Q. I notice on the record here of the Veterans Administration that you had what they call a sequestrectomy of the left tibia on May 11, 1953.

A. Yes.

Q. It that about the date of your first operation up there? A. Yes.

Q. And that on May 27, 1953, you had a skin graft, pedicle, first stage, from right to left. What was done in that operation, do you recall?

A. They went in again and scraped the left leg, and then they cut a flap of skin off my right leg, and put me in a cast with my legs crossed, and I was that way for six weeks.

Q. That was the second operation you had up there? A. Yes.

Q. Was flesh removed from your right leg?

A. Yes.

Q. Can you show us the spot or spots where the

(Testimony of Amos R. Morin.)

skin was removed? A. Yes.

Q. Has that healed over?

A. Pretty well.

Q. I would like to describe it as a concave removal of flesh from the calf of the right leg, approximately six inches [176] in length and about three and a half to four inches in width. Is that about right?

A. Yes. It has healed over, but it is still very tender.

Q. The record also shows that on May 27, 1953, you had a skin graft, split thickness, left thigh to left leg. A. Yes.

Q. Is that site healed now?

A. Yes, it is healed.

Q. Is there any scar there?

A. Yes, there is a scar. The surface of the skin was cut off.

Q. You had a further operation on June 29, 1953, a skin graft of the right calf. Was that in the same site as you pointed out as to the right calf?

A. Yes.

Q. Did you have a skin graft made from any other portion of your body?

A. I had a total of fifteen skin grafts.

Q. Done at different times?

A. At different times.

Q. You mentioned your right calf.

A. The right calf, my buttocks, my left calf and then back up right here (indicating)——

Q. Those were all for grafts to the site of your

(Testimony of Amos R. Morin.)

original wound? [177] A. Yes.

Q. It is indicated by the record that the last of these grafts was taken in February, 1954. Is that correct? A. Yes.

Q. Have you had additional hospitalization since then? A. No.

Q. You have been under no treatment since then?

A. I go up every week to Dr. Cherry.

Q. Have you been able to work?

A. I started to work April 1st, 1954, and up to the present date I have been able to keep on. I watch what I am doing and protect my leg. I use a heavy bandage over my left leg to keep it from barking up. I watch myself, and I get my wages anyway.

Q. At the present time do you have any pain in your left leg? A. Very much.

Q. Very much? A. Yes.

Q. Would you describe the type of pain you suffer?

A. It just hurts; throbs and pains real deep. I can't exactly describe it.

Q. Is there any drainage from the site of the wound? A. It still drains, yes.

Q. It is still draining? [178] A. Yes.

Q. With regard to the use of your left leg, do you have to guard it? A. Yes.

Q. Are you able to walk?

A. Yes, if it is not too far or too rough. I can't run.

Q. Do you feel fatigue in your left leg?

A. Yes.

(Testimony of Amos R. Morin.)

Q. Is it greater than previous to your injury?

A. Yes.

Q. Have you any weakness in your ankle or your lower left leg? A. That hurts me quite a bit.

Q. How about the right leg where the skin graft has been taken?

A. That don't bother me too much; it is just tender. It is still tender. It is tender yet, but it don't bother me too much.

Q. Mr. Morin, you worked as Third Mate on the Wahkiakum and you are presently doing that work, is that right? A. Yes.

Q. How much longer do you have before retiring from that job, which is a civil service job?

A. Ten years.

Q. Ten years? [179] A. Or twelve years.

Q. What do you make, approximately, a month at that job?

A. About $450, bring-home pay.

Q. Will you describe to us how you are able to do your work on the job?

A. Since April I have done it; I try to hold up my end of my work. It hurts sometimes, but you have just got to do it.

Q. Does your left leg limp when you walk?

A. Slightly. I try not to show it because I don't want my boss to know it.

Q. Is your job a pretty active job?

A. Yes, it is.

Q. Describe the type of your activities?

A. I have quite a bit of walking, quite a bit of

(Testimony of Amos R. Morin.)

lifting and pushing pipe and running the machinery, and jumping up and down.

Q. Do you notice any difficulty in doing that over your former ability to do it before you had this injury?

A. Oh, I have got to be very careful of the way I do it. I do it, but I do it in a different way now.

Q. Would you tell us how you do it by a different way?

A. I usually try to have a support to hang onto; use one hand to hang on when I jump down. I can't run. I have just got to walk and get there that way.

Q. With regard to your private life, were you athletic, [180] athletically inclined, or engaged in sports? A. Very much.

Q. What were those sports?

A. I loved to play tennis, go hunting and fishing. I played football with the boys and we played indoor baseball; used to play every Sunday.

Q. Are you engaged in those sports now?

A. No.

Q. Do you play tennis? A. No.

Q. Did you play tennis previously?

A. I did.

Q. Are you able to play that at all now?

A. No.

Q. How frequently did you play tennis?

A. Once a week anyway.

Q. Do you live near a park? A. Yes.

Q. There was some mention of dancing in your

(Testimony of Amos R. Morin.)

wife's testimony. Were you and your wife accustomed to go dancing?

A. We used to go out at least once a month, more than that sometimes.

Q. Are you able to dance at all? A. No.

Q. Have you attempted to do it? [181]

A. No, I have not.

Q. Your boys, I believe, said that they enjoyed swimming. Did you go swimming frequently in the summer?

A. In the summer, yes. Of an evening, we used to go out——

Q. Where did you go?

A. The Sandy River and out on the Columbia.

Q. Have you been able to enjoy that sport since the injury?

A. No, because my leg is still paining. I don't want to run any chances.

Q. What have you been told with regard to whether you will need any further treatment?

A. I am due to have—the doctor said that I should have a sequestrectomy. What that is I don't know, but that is what the doctor told me.

Q. Who told you that?

A. Dr. Davis and Dr. Cherry. Dr. Davis is chief at the Veterans Hospital, and he is with Dr. Cherry.

Q. In the pre-trial order it is set out that you had a wage loss of $6,388.32 since the time you fell from the ladder at your home. Is that a correct computation you made of the amount of wages you have lost?

(Testimony of Amos R. Morin.)

A. No, not quite. I see here when I worked it out I added $781 to the time that I worked, to the total amount, which should not have been. I lost $5,607.

Q. That is what you estimate your wage loss to be? [182] A. Yes.

Q. Would you repeat that figure, please?

A. $5,607.12.

Q. Mr. Morin, without taking the time to go into all the details of your wage loss, since Counsel and I have prepared a statement setting forth all of that, would you tell us about the annual leave in your work?

A. Annual leave is on a basis of two and a quarter days per month, which builds up to a certain amount every year. You can't get over 21 days in one year, but your sick leave, which mounts up to two and a half days per month, will carry on and build up just as far as you want it to go.

Q. As to your cumulative annual leave of two and a half days a month, are you able—are you paid when you take that?

A. Yes. You have to take your hours of accumulated leave—you take it any time you want to take it if it is satisfactory with them, satisfactory with your skipper or your boss aboard your vessel.

Q. Would you tell us what sick leave is?

A. If you are sick at any time, when you are not able to report to work, you are allowed two days' sick leave. Over that amount you have to have a doctor's certificate stating why you are ill over that length of time, to start back to work. [183]

(Testimony of Amos R. Morin.)

Q. Those first two days are on pay?

A. They are all on pay, but you are allowed two days on pay without a doctor's certificate.

Q. Is there a limit to the amount of sick leave you can take?

A. The amount you have built up.

Q. How do you build up your sick leave?

A. Two and a half days a month.

Q. Two and a half days a month sick leave?

A. Yes.

Q. What happens after you use up the accrued sick leave you build up by reason of your service?

A. You go on leave without pay.

Q. How long can you be on leave without pay?

A. That is up to the discretion of the master.

Q. Based on your condition, whether justifiable or not? A. Yes.

Q. Is there any limit to the amount of time you can take off from your job without losing your job?

A. Yes.

Q. What is that limit?

A. The time set by the head of your department, and how they feel as to how long you shall be off.

Q. That applies to the individual case, then?

A. Yes. [184]

Q. Has there been a time set, as to how much time you could take off your job?

A. Yes. I had to be back to work by April 1st or else lose my job.

Q. Has there been any further discussion with

(Testimony of Amos R. Morin.)

your superiors with respect to future absences for sick leave?

A. As yet, no. I have 19 months work before I pay back what I owe them for advancing me sick leave when I was up in Seattle. I have to pay that back, 30 working days of sick leave.

Q. You have to pay back these 30 days of sick leave?

A. Yes, before I can get any more sick leave accumulated.

Q. Did you get sick leave or vacation leave during any of the time you were off?

A. Yes, I had annual leave when I was—I used up my sick leave and then they allowed me 30 days more sick leave up in Seattle, and then I had from 9/18/52, to 10/2/52, annual leave coming, and I used that up. That is all I had.

Q. Did you lose any time during this period when you did not have any leave coming?

A. Oh, yes.

Q. I believe that will be revealed in the information we have? A. Yes.

Mr. John D. Ryan: No further questions. [185]

Cross-Examination

By Mr. Harr:

Q. Since we are talking about the time lost, your claim against the Government begins from the date of your injury, is that right? A. Well——

Q. Your contention in the pre-trial order is that

(Testimony of Amos R. Morin.)

you claim time lost from June 11, 1952, until September 18, 1952, a total sum of $1,255.80. You want the Government to pay you for that, don't you?

A. Well, I would say, sir——

Q. I think you can answer that by yes or no. It is part of your claim, is it not?

A. I am trying to be fair about this, sir.

Q. Is it or isn't it? Say yes or no, and then you may clarify it. A. I will say, yes.

Mr. Thomas H. Ryan: You go ahead and explain.

Q. (By Mr. Harr): Yes, you may explain if you want to.

A. I would say my injury, if I had been treated properly, would have taken six months. I am asking pay for the time of my injury, for the reasonable length of time until I should be well.

Q. That is the first time loss you had, from June 11th to September 18. You drew on your sick leave first, didn't [186] you? You exhausted your sick leave?

A. I had very little sick leave coming at the time of my accident.

Q. A note that we have from one of your employers says that from June 11, 1952, to September 18, 1952, you were allowed that for sick leave but it included the 30-day advance?

A. Yes, that is sick leave.

Q. And then from June 11th to August 18th was sick leave you had accumulated. That is right, isn't it? A. June 11th to September 18th?

(Testimony of Amos R. Morin.)

Q. June 11th to August 18th?

A. No, sir. That is figured on a five-day week, so that would be six weeks of sick leave that I was advanced. It is not figured on a seven-day week. It is figured on a five-day week.

Q. I think you are right about that.

A. Yes.

Q. In that first bracket you were paid the sick leave that the Government allowed you?

A. That was just a loan.

Q. Now, you say that the Government should pay you that again. I would like to know why.

A. I just got through saying, sir, that I figured that in six months, if I had had proper treatment, six months would [187] have been plenty for this injury. I am asking only for six months taken off for this injury to heal and be back to work.

Q. All right. Assuming that, if you had been back on your job in six months, and according to your version the treatment would have been highly satisfactory in every way to you, you would still have used up the sick leave, wouldn't you? You could not have your sick leave once and then get it again, could you? A. No.

Q. You shake your head, "No."

A. I said no, sir.

Q. Why do you make another claim, now, for that sick leave?

A. I just got through telling you, sir, I would allow six months total for rehabilitation, to get back on my feet and get back on the job. They asked me,

(Testimony of Amos R. Morin.)

when I made out this slip, to find out the total time I was sick, the total time I lost during the time I was sick. That is what I have done.

I am saying that if I had gotten the right treatment at the Physicians and Surgeons Hospital, I would have been back to work easily in six months' time.

Q. From June 10th to December 10th, six months—— A. Yes.

Q. So, had you received proper treatment, in your view, during that period, you would have been at work and, therefore, [188] you would have had no claim against the Government?

A. If I had got the right treatment, then I don't think I would have had this trouble.

Q. Then I will ask you this question: Had that occurred, you would have used up all of your sick leave, and you would have used up all of your annual leave up to that point and you would also still have to pay back 30 days' advance sick leave that they granted. That is true? A. Yes, you are right.

Q. So, now, because of the fact you figure you did not get the treatment you should have, you are asking the Government to pay you all the wages you would have otherwise earned?

A. I have not, sir.

The Court: Don't waste time. He is claiming after December 10th, beginning December 10th.

Mr. Harr: Very well, your Honor.

The Court: Isn't that what you say?

The Witness: Yes.

(Testimony of Amos R. Morin.)

Q. (By Mr. Harr): You made the statement that you had three sources of treatment, the Blue Cross, the Veterans Administration, and then you said, "I am insured through the Public Health Service." A. Yes, sir.

Q. You do not mean to imply that there is an insurance policy? [189]

A. We are covered by the Seamen's Act for hospitalization and doctors.

Q. Yes. There is a statute that requires the Public Health Service to give treatment to sailors. That is true, isn't it? A. Yes.

Q. You being a man aboard a dredge, you are so classified as being a seaman? A. Yes.

Q. So the treatment is available to you if you want it? A. Yes.

Q. And that is by statute, isn't it? A. Yes.

Q. What you meant was that you merely had that as insurance to rely on? A. Yes.

Q. You could get it if you asked for it?

A. Yes, that is right.

Q. You did ask for it in this instance, didn't you? A. Yes.

Q. This Dr. Brown you spoke of talking to in Seattle, did you know he was one of the exchange doctors who had come from some other area?

A. At the time I didn't know anybody.

Q. He was a Negro doctor, wasn't he? [190]

A. Yes, he was a Negro doctor, but at the time I knew nothing——

The Court: He was what?

(Testimony of Amos R. Morin.)

Mr. Harr: A Negro.

The Witness: He was a Negro doctor.

The Court: What?

Mr. Harr: A Negro doctor, your Honor.

The Court: What difference does that make?

Mr. Harr: It makes no difference at all.

The Witness: I didn't know him. What was your question?

Q. (By Mr. Harr): Well, he was an exchange doctor?

A. I don't know whether he was an exchange doctor. I didn't know until——

The Court: What is an exchange doctor?

Mr. Harr: A doctor, your Honor, coming from some other Public Health Service. They exchange as school teachers exchange. It has no significance. In other words, he was not on the regular staff.

Q. You entered the Seattle hospital June 12, 1952, and your leg was treated and a cast applied. Then the cast was removed, wasn't it? First, a window was cut in it and then the cast taken off.

A. On the Monday before July 11th, they bi-valved it and then they put it back with tape. [191]

Q. That was on July 9th, as the record shows.

A. Yes.

Q. Would that be about right?

A. I think so. I don't know the exact date. You have that information.

Q. The record indicates that on July 9th, the cast was bi-valved and padded, is that right?

(Testimony of Amos R. Morin.)

A. If that is what is on the record, that must be correct.

Q. And that night you tore the cast off, didn't you? A. No, sir.

The Court: What date are you talking about?

Mr. Harr: July 9th.

A. No, sir.

Q. (By Mr. Harr): You did not?

A. No, sir; not to my recollection; I never removed a cast in my life. I don't see how I could.

Q. The record indicates that this cast remained off until July 11th, when you went under general anesthesia. Was the cast off, then, those two days?

A. Yes.

Q. That is when they performed the bone graft?

A. Yes.

Q. Did you see that bone during those two days?

A. Through the window that they had cut in it. On my leg, are you speaking of? [192]

Q. Yes, during the two days the cast was off.

A. No, the cast wasn't completely off at any time. It had a window in it and bi-valves were cut down the side. They came in on a Monday and bi-valved my cast at Seattle.

They was figuring on taking me on a Wednesday, but something came up—I wouldn't know what—and they said they couldn't get to me, so they were going to take me up on Friday. Until the time it was bi-valved, it had a window cut in here (indicating).

Q. But the cast was still on your leg?

(Testimony of Amos R. Morin.)

A. The cast was still on my leg.

The Court: What is the word he used, bi—what?

Mr. Harr: "Bi-valved."

The Witness: It is a slit right down the side.

Q. (By Mr. Harr): You mentioned on your direct examination, Mr. Morin, two or three places, something to indicate—one would get the conclusion you were rather upset or unhappy with the treatment you were getting at Seattle; that is true, isn't it?

A. Not the Seattle treatment. I was just unhappy at my condition. I figured I could better myself by going to an orthopedic specialist.

Q. Are you saying that in that big institution, the Marine Hospital, they did not assign doctors to you in whom you had any confidence at all? Is that right? [193]

A. I have nothing against the Marine Hospital. I have got nothing against it.

Q. You suggested you were just wasting your time. You figured you were not getting anywhere, I think you said. That was one of your remarks.

A. I would be better satisfied in Portland with my family and under an orthopedic specialist.

Q. Is Dr. Thorup still your family doctor?

A. Yes.

Q. He is still in Portland?

A. He is taking a nice vacation over in Switzerland.

Q. You spoke about your operation by Dr. Cherry. That was in January, 1953? That is right,

(Testimony of Amos R. Morin.)

isn't it? A. January 26th, I believe it was.

Q. You mentioned that there was sloughing and matter coming through the cast.

A. There was sloughing before, when Dr. Cherry took over.

Q. Your leg was in a cast, wasn't it?

A. It had a window in it.

Q. You saw the wound before that time?

A. Oh, yes.

Q. Had the cast been removed completely before that time? A. What date?

Q. January of 1953.

A. It was removed by Dr. Thorup on August 15, 1952, when he took a [194] picture and put another cast immediately back on.

Q. Did you see the wound on that occasion?

A. Yes.

Q. Shortly thereafter you went to the hospital where they performed this operation?

A. Yes. Dr. Cherry can explain that better than I.

Q. In other words, were you under an anesthetic at that time? A. Yes.

Q. In your testimony you jumped rather hastily from that point until the January operation. Can you fill in the details in the meantime, between the time you had this "pressure operation" as you call it, from that time until January?

A. I was back at the hospital for—I think it was over a week. I think my counsel has got the date when I went back to the hospital for a cast change

(Testimony of Amos R. Morin.)

and, if you will consult them, you will see that I was under the immediate care of Dr. Cherry at all times.

Q. From August until the present time——

A. Until the present date?

Q. That is what I am talking about.

A. Until the present date, yes.

Q. You were under Dr. Cherry's care at all times? A. At all times. [195]

Q. You also went, did you not, to the Public Health Service in this building? A. Yes.

Q. During that period? A. Yes.

Q. They took X-rays of you and followed your condition and treated you?

A. They took a cast off, yes. I am a poor man. I couldn't afford——

Q. I just wanted to know what happened. You made many calls, down in this building, at the Public Health Service?

A. Yes. I also asked Dr. Morrison why they sent me up to Seattle, and he said they didn't have no money to keep me here.

Mr. Harr: Your Honor, I object to that and move that it be stricken.

The Court: It may stand.

Q. (By Mr. Harr): You had some treatment during this time for ulcers?

A. Oh, that has been quite a few years ago. You can find the exact date in the records.

Q. You had a gastric ulcer a couple of years before this accident; that is true, isn't it?

A. Yes.

(Testimony of Amos R. Morin.)

Q. Didn't you have some treatment while in St. Vincent's [196] Hospital? You went up there. Didn't they also give you treatment for ulcers?

A. I might have had heartburn one night or so, but I had no treatment. I might have had heartburn or something like that.

Q. Didn't you have trouble with your sinuses?

A. Once in a while.

Q. Had medication for that?

A. In the wintertime my sinuses bother me once in a while, when I catch cold and it settles in my head.

Q. There is drainage from your sinuses?

A. That is when it hurts, when it don't drain.

Q. But you do have trouble in the wintertime?

A. Not usually; only when I get colds.

Q. During this time you were coming to the Public Health Service, after you came back to Portland, after Dr. Cherry manipulated your leg and put a cast on, then you asked for a ticket to go back to work? A. I had a ticket, yes.

Q. Yes. That was with Dr. Cherry's approval, wasn't it?

A. He thought if I could stand it, it wouldn't hurt me any more. My leg was in a cast.

Q. Then you did go back to work. What date was that, the first day you went back on the job?

A. January 8, 1952. [197]

Q. As a matter of fact, you went back on December 8, 1952? A. That is when I said.

Q. December 8, 1952? A. That is right.

(Testimony of Amos R. Morin.)

Q. Then you worked from December 8, 1952, until December 20, 1952? A. January 23rd.

Q. The 23rd of January? A. Yes.

Q. Where did you work?

A. I was a watchman at the moorings on St. Helens Road.

Q. Didn't you go down onto the dredge first?

A. Not at first, no.

Q. Are you sure?

A. Maybe I did, sir. Maybe I did. Maybe that was the time I went down there. I still had my cast on. They gave me a job on the steam donkey, on the elbow donkey on the river.

Q. Isn't it a fact that you worked on the dredge and did your regular duties?

A. No, that wasn't my regular duties.

Q. Are you sure about that? A. Yes.

Q. December 8, 1952, until December 20th?

A. Yes. [198]

Q. Then, is it not a fact you took a job as guard at the moorage on December 21st, and continued to do that until January 23rd?

A. No, I took a job of watching, if my memory serves me right, and if I can read these figures right, February 24, 1953, to April 26, 1953.

Q. Regardless of where it was——

A. Yes.

Q. ——you worked from December 8, 1952, to January 23, 1953, then? A. Yes.

Q. That was all in one stretch, wasn't it?

(Testimony of Amos R. Morin.)

A. Yes.

Q. During all that time were you on the dredge?

A. Five days a week.

Q. The time you worked you were on the dredge—— A. Yes.

Q. ——during that period? A. Yes.

Q. You say you were on what?

A. I was on what they call the elbow donkey. It is the place where that pipe comes out from the dredge and then makes a curve to head to the beach. They was kind enough to give me work.

Q. Is that Mr. Oja who gave you that job? [199]

A. Yes.

Q. Did he assign you to that?

A. Yes. Mr. Sandwick gave me this job in the yard as a watchman.

Mr. Harr: I think that is all, your Honor.

Mr. John D. Ryan: We have no further questions.

(Witness excused.) [200]

DR. HOWARD L. CHERRY

produced as a witness on behalf of Plaintiff, and being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. John D. Ryan:

Q. You are Dr. Howard L. Cherry?

A. Yes.

Q. Are you a medical doctor? A. Yes.

(Testimony of Dr. Howard L. Cherry.)

Q. Do you practice here in the City of Portland?

A. Yes.

Q. Where do you practice? Where are your offices?

A. Our offices are in the Standard Insurance Building, Ninth and Washington.

Q. What are the names of your associates in your field?

A. The firm name is Drs. Blair, Thatcher, Davis and Cherry.

Q. Doctor, would you give us a statement of your professional training?

A. I graduated from Oregon State College in 1938——

The Court: Let's all concede he is one of the leading orthopedists in the city. I have heard him many times. Is that agreeable to you?

Mr. Harr: Yes.

Q. (By Mr. John D. Ryan): Did you treat the plaintiff in this case, Amos Morin? [201]

A. Yes, I did.

Q. When did you first see him?

A. Going by the record——

Mr. John D. Ryan: Would you hand Dr. Cherry Exhibit No. 6, please. Your Honor, Exhibit No. 6 consists of the records of Providence Hospital.

Mr. Harr: This record was produced pursuant to a subpoena.

Mr. John D. Ryan: They are in a white folder.

The Court: What date was that?

Mr. John D. Ryan: I can't give you the date.

(Testimony of Dr. Howard L. Cherry.)

The Court: About how long ago?

Mr. John D. Ryan: These particular exhibits were in the Clerk's office with the exception of this one, by agreement of counsel. It does not seem to be here. The only other place it could be would be in the Clerk's office.

The Court: The Clerk's office is a big institution.

Mr. John D. Ryan: They were in the vault in the Clerk's office.

(Intermission.)

The Witness: I think I can answer your questions anyway.

The Court: See what you can do without it. The Clerk has gone to see if he can find it. [202]

Mr. John D. Ryan: You may answer that question, then.

A. I can answer that question. I saw him first apparently on August 24, 1952, at Providence Hospital in consultation with Dr. John Thorup.

Q. Did you at that time make an examination of Mr. Morin? A. Yes.

Q. What were your findings?

A. My recollection is that he had a cast which was removed and his wound examined. Dr. Thorup brought with him the X-ray that he had taken, and the history of the bone fracture having been operated previously at Seattle.

The wound at the time I saw him was on the left tibia. It had a slight amount of drainage. The skin around this wound was in very poor shape; circula-

(Testimony of Dr. Howard L. Cherry.)
tion was poor, and it was discolored and the skin was shiny.

The bone itself was angulated. X-rays showed the fracture was not yet solid.

Q. Could you tell us what you mean by angulation?

A. In setting a fracture we attempt to get the two fragments, the upper fragment and the lower fragment, in a straight line, as the tibia normally is.

Q. What did you then do to Mr. Morin?

A. It was my opinion that this should be straightened. When such fractures are not solid yet, it could be done easily, not requiring any further breaking of the bone, so he was [203] given an anesthetic and the fracture straightened without opening the skin or anything, just with my hands we straightened the leg at the fracture site and my recollection is that we cast it. Then we straightened it up a little more after we had it in the cast. Then he was kept in the cast and observed and the cast changed at appropriate intervals until his bone became completely solid.

Q. Was Mr. Morin in a cast when you saw him at your initial examination?

A. My recollection is that he was.

Q. It was at the hospital where the examination took place? A. Yes.

Q. This operation you speak of took place soon thereafter, the next day?

A. I don't recall the date. I could tell you if I had the hospital record here. It was very soon there-

(Testimony of Dr. Howard L. Cherry.)

after, but whether it was the next day or in two or three days, I don't know, something of that nature.

Mr. John D. Ryan: Your Honor, we have the Providence Hospital records, Exhibit No. 6.

The Court: Go ahead.

Q. (By Mr. John D. Ryan): This operation was done immediately after or soon after the examination?

A. I don't like to use the term "operation." "Operation" to us implies a cutting procedure. This manipulation, as I [204] call it, was on the 25th of August.

Q. Was there infection present in the wound at the time you saw him on August 24th?

A. I don't know what is coming up out of this, but I think the term "infection" should be defined a little bit.

There was drainage present; there was a crusting on the wound; the skin was discolored and warmer than normal; its appearance was not normal. It looked critical, that the entire thing might break down.

In answer to your question, the answer is yes, there was infection present. It was not enough at that particular time to make him sick, but it was very unhealthy tissue and there was some infection present, and there was enough that we were much concerned about it.

Q. You remarked that the skin around this wound site was shiny. A. Yes.

(Testimony of Dr. Howard L. Cherry.)

Q. Give us the significance of that.

A. All these things, the purple appearance, the shiny skin, and being warm, indicates that it is not good, healthy skin. This skin, of course, is directly over the bone. It just had the appearance that it probably would not hold up.

Q. After the reduction, the plaintiff stayed in the hospital for some time?

A. This time he was there from August 24th to August 28th. [205] He was in the hospital four days.

Q. After that, Doctor, did you give him any further treatment, after removal of the cast?

A. I saw him at regular intervals, checking by X-rays and changing the cast as needed until the fracture was solid.

Q. On these occasions, had you reason to observe the wound site, Doctor?

A. Yes, I observed it. The wound site actually gradually got worse, until we had to rehospitalize him for further treatment.

Q. When was that further treatment given? What was that further treatment and when was it given? I believe the record shows you had him in there on January 24th.

Q. He was readmitted to Providence Hospital on January 24, 1953. We had been successful in uniting the fractured bones until they became solid, where he had a good bony union.

However, the skin and soft tissue, the condition of the skin and soft tissue had become much worse.

(Testimony of Dr. Howard L. Cherry.)

As I recall, it was draining at the time he came in. Ordinarily, if it was there at first we would have operated and taken the plate out because the plate and screws consist of foreign materials and tend to keep this going.

However, we did not do it earlier because, if we had, we would have found less fixation of the fracture site and it would not go on to heal. The reason for that time lag [206] is that the fracture should heal and become solid so we could safely take the plate out, without losing the healing of the fracture.

Q. After removal of the Egger's plate, did you continue to see Mr. Morin?

A. I might mention a little more about it, about this drainage. When we removed the plate, the infection was going down into the bone, and it involved the bone. We took this plate out and then I continued to see Mr. Morin, yes.

Q. You say the infection then was going down to the bone?

A. Yes, there was bone involvement at that time.

Q. As to the wound site, was there any healing over the site?

A. Then the wound site became progressively worse, where it did not have an adequate blood supply to heal this wound.

Q. What was your subsequent treatment of Mr. Morin?

A. We watched him, hoping that we could get this thing healed without having further hospitalization, but it became rather obvious that he would

(Testimony of Dr. Howard L. Cherry.)

have to have a skin graft to replace these defects in the skin, and, because of economic reasons, it is my recollection that I advised that he should have this done at the Veterans Hospital, so he was then admitted to the Veterans Hospital for the first time, and the doctors there took over primary care.

Q. Did you continue to see the plaintiff? [207]

A. I continued to see the patient, not at frequent intervals but at considerable periods, for two reasons: One, I was, myself, interested in this rather critical leg and, the other, that I am not employed by the Veterans Hospital, but I was trained there and I had a teaching residency there, and I keep in pretty good touch with the residents and the doctors at the hospital; so I did keep up to a fair degree in what was going on in his case. I was not responsible in any manner at that time.

Q. Was your associate, Dr. Davis, treating the case?

A. Dr. Davis is a consultant and is in on most of the surgery in orthopedics at the Veterans Hospital, and supervises all work that is done there. He is up there about four days a week for some length of time.

Q. When did you last see the plaintiff?

A. I last saw Mr. Morin in my office on July 14, 1954.

Q. Will you explain some of these terms to us? What is the significance of drainage which, by your testimony, you found existing when you first examined the patient on August 24, 1952?

(Testimony of Dr. Howard L. Cherry.)

A. Drainage is due to bacteria, to a bacterial infection, which is present in the wound, essentially pus.

Q. Was there any granulation tissue present at that time, at the time you examined him?

A. I would say there was a small amount of granulation [208] tissue around the edge; it wasn't large——

Q. What is granulation tissue?

A. Tissue that is set up in a wound in an effort to repair, Nature's effort to repair the wound. It gradually changes over into scar tissue and closes the wound over in a normal repair process, in which there is exposed tissue.

Q. Had you reason to observe the condition of the circulation in the left lower leg? A. Yes.

Q. This was on August 24th? A. Yes.

Q. Describe to us what you did with regard to the circulation, what you observed, and so on.

A. The general circulation of the leg was very satisfactory, though the local circulation around the wound was very poor. The skin was dry, and it was critical locally in the region of the wound.

Q. Tell us what you mean by "critical locally in the region of the wound."

A. Locally; that means in the immediate proximity, within an inch or so of the wound. "Critical" —we use that term in relation to whether the circulation and the tissue is good enough to heal that wound. It could go either way. It could not heal or could heal. If it were good tissue, if he had good

(Testimony of Dr. Howard L. Cherry.)

skin, good soft tissue around that wound and [209] not a large amount of drainage, it would go right ahead and heal.

We were scared, for it was critical and we thought it might not go ahead and heal, which it subsequently did not do. The term "critical" has nothing to do with the patient's general condition; that is, of life and death.

Q. You are particularly referring just to its ability to heal? A. Yes.

Q. At the time you saw him, had the patient given you a general history of his treatment?

A. Yes, in a general way.

Q. Had he informed you he had been treated initially at Physicians and Surgeons Hospital?

A. Yes.

Q. Can you tell us what he told you about his treatment?

A. Well, he told me he had been sent by Dr. Done and he was treated there. I asked him if he had been operated and given an anesthetic and he told me he had not.

I asked him how long he was there and it is my recollection that he told me he was transferred on the third hospital day. It would be two days or the end of the third day when he was transferred—I am not sure of the hours.

I asked him what they did for him and he said that [210] the doctors did not give him any anesthetic, did not operate on him, but put him to bed. Obviously, a layman cannot give accurate details of

(Testimony of Dr. Howard L. Cherry.)

the care received, but they do know whether they are given anesthetic and things like that.

Mr. Harr: This is the history that Mr. Morin——

The Witness: This is what Mr. Morin related, yes. I was not involved in it, no, of course.

Q. (By Mr. John D. Ryan): You have been handed Plaintiff's Exhibit No. 1 and Plaintiff's Exhibit No. 2, A and B, Doctor, the X-rays from Physicians and Surgeons Hospital. I believe you have the clinical record of the Physicians and Surgeons Hospital there. This is Plaintiff's Exhibit No. 1. A. Yes.

Q. Are you familiar with that exhibit? Have you seen it?

A. I have seen this before, or a photostatic copy of it.

Q. And you have examined it in detail?

A. Yes.

Q. You have in your hand Exhibits 2-A and 2-B, which are X-rays taken of the plaintiff at the Physicians and Surgeons Hospital, June 10, 1952. Tell us what you read from those X-rays.

Q. Is this the only X-ray on this date? This——

A. This contains only one view. Usually they are taken in two views.

Q. There are two X-rays. [211]

A. There is an X-ray of his back, one picture of his back; there is one picture of his leg, one view.

Q. Those are the only ones we have been given. We subpoenaed those.

A. In order to make a complete examination of

(Testimony of Dr. Howard L. Cherry.)

a leg, by X-ray, it should be taken in two views, but let's forget about that. This shows the fracture very adequately.

Mr. John D. Ryan: Here is Exhibit 2-C which I will presently hand to the witness, and Exhibits 2-D, 2-E, 2-F and 2-H.

(X-rays handed to the witness.)

Q. You have not had an opportunity to see those before? A. I have not seen these before.

Q. They were not available when we looked at the other records?

Mr. Harr: I do not believe that is correct. I think they were in the Clerk's office.

(Intermission.)

Q. (By Mr. John D. Ryan): Have you had an opportunity to look at those? A. Yes.

Q. Would you give us their significance, as far as reading them is concerned?

A. These are films dated June 10, 1952. They have the [212] name of Amos Morin and the name Dr. Lee A. Craig, and Physicians and Surgeons Hospital.

Q. As you read each film, would you give us the exhibit number of it?

A. The exhibits are 2-A and 2-B. 2-A is one of an AP view of the tibia and fibula. That is taken with the tube in front and the film behind.

2-B is a lateral view of the tibia and fibula; it is not quite full length. It does not show the angle.

(Testimony of Dr. Howard L. Cherry.)

These two films show a fracture of the tibia and fibula. The tibia is the large bone and the fibula is the small bone.

There are three separate fractures here. There is a fracture of the tibia at about the junction of the middle and lower third; a fracture of the fibula approximately one inch further toward the ankle from the tibia fracture, and a second fracture of the fibula right here (indicating). This is the fracture of the tibia (indicating).

In considering these fractures, we are interested almost entirely in the tibia. We are not particularly concerned about the fibula.

This shows a complete irregular fracture that is completely offset; that is, the bone is completely in two and the offset is a little more than the width of the [213] bone.

On the other view, the smaller fragment is posterior and offset approximately half the bone.

Another point of interest here is that in looking at the soft tissue we can follow this line of soft tissue, the muscle, fat and skin, and in this X-ray it appears that the fragment is outside of the skin. Not always can we tell it by X-ray, but in this film we can safely say that this is a compound fracture, so our diagnosis would be a fracture of the fibula and tibia, compound, with a severe displacement.

Q. Look at the other X-rays and tell us what they show.

A. Again I would like to mention that I have not seen these films before and sometimes films are best

(Testimony of Dr. Howard L. Cherry.)

studied for a length of time, but I can look at them quickly and give you my impression.

This one is No. 2-B. On the back of the film it states it was taken on 6/10/12—I mean 6/10/52—of the patient Morin.

This is a lateral view of the lumbar spine, down to the pelvis. The film is taken with the X-ray machine showing across the body.

This shows a compression fracture of a vertebra between the—I can't tell for sure which vertebra it is from this film. It looks like either the first [214] or the second lumbar vertebra. It is a real fracture and it is acute, and I would classify it as mild, moderate in deformity.

This is an AP film of the pelvis and the lower part of the lumbar spine, and taken with the tube in front and the film behind in this lower region.

It shows the sacrum and the sacroiliac joint and lower vertebrae, but I see no evidence of fracture in any area covered by this film.

This is an X-ray—this is Exhibit 2-G, taken on 6-10, and Mr. Morin's name is on the film.

It is taken AP, with the film in front—excuse me —with the tube in front and the film behind.

It has the same projection as the last film except it is higher. This shows the lumbar vertebrae and the first dorsal vertebra, the dorsal vertebrae being the ones to which the ribs are attached.

This shows a fracture of—I would call it the second dorsal—the second lumbar on this film. I cannot, again, be completely sure, but it does show the

(Testimony of Dr. Howard L. Cherry.)

fracture, but it is not seen as well as on the lateral view film.

Exhibit 2-F is taken the same date; has Mr. Morin's name on it. This is what we call a condyle-film; it is taken laterally, the same as the one before. It is taken to show greater detail, and it again shows a fracture of a lumbar vertebra. [215]

This is Exhibit 2-H, dated 6/10, and it again has Mr. Morin's name on it. This is a lateral view, taken low down. I do not see any evidence of recent injury in this film.

Q. Will you take Plaintiff's Exhibit No. 1, which is the record of treatment at the Physicians and Surgeons Hospital? A. Yes.

Q. Would you turn to the third page in that record where there is a description of the diagnosis entered there.

A. The diagnosis is on the second page, I think.

Q. Have you got the admission and discharge record? A. This is the second page.

Q. Would you be kind enough to read the diagnosis as written there and then say whether that corresponds with your findings as to the reading of the X-rays which you have now made?

A. I have the final diagnosis, Exhibit 1. It reads: "Fracture, oblique, left tibia, junction of lower and middle thirds; fracture, oblique, left fibula——"

That is correct, except there is one glaring omission. They don't say whether this is a simple fracture or a compound fracture, but the description is

(Testimony of Dr. Howard L. Cherry.)

otherwise correct of that fracture, except it should say "compound."

Q. Does the remaining portion of that description correspond with your reading of the [216] X-rays?

A. "Fracture, oblique, left fibula; fracture, left fibula, proximal portion, not displaced; compression fracture of the 1st lumbar vertebra."

That diagnosis is entirely correct except it would have been better to have said whether it was compound or simple.

Q. You were familiar, from your history taken of Mr. Morin, with the manner in which he was injured? A. Yes.

Q. Would you tell us what that was?

A. As I recall, he fell from a ladder.

Q. Yes, on June 10, 1952, it has been established, sometime between noon and 12:30. Would you be kind enough to turn to the laboratory record?

A. Yes.

Q. Would you read that laboratory record, which was read previously, and tell us if it has any significance, any clinical significance, at this time?

A. This has no significance.

Q. At this time?

A. This is dated 6/10. The urine is a little concentrated, but it is not too bad.

Q. There is an X-ray record entitled, "Lumbar Spine, Pelvis and Left Leg," signed by Dr. Isenhart.

Would you read that and tell us whether [217]

(Testimony of Dr. Howard L. Cherry.)

that corresponds with your findings as to the X-rays?

A. I believe that is entirely correct; all the statements are correct there. He does not mention whether that had the appearance of being compound or simple, but his description of the fracture is very accurate.

I might say that usually a radiologist does not say whether a fracture is compound or simple, because it is so easy to tell otherwise. I would not criticize the reading, and, also, the X-ray evidence is not as conclusive as an examination of the wound, so there is no criticism of the reading. I think the reading is very accurate.

Q. Would you turn to the temperature chart?

A. Yes.

Q. First, turn to the doctor's order sheet.

A. Yes.

Q. You examined this before trial?

A. Yes.

Q. The doctor's sheet, 6/10/52, Physicians and Surgeons Hospital. It indicates some medication was given at 1:45 p.m. What is the medical significance of that type of medication?

A. Penicillin, S.R., 400,000 units, et cetera. This is a rather large dose of penicillin given twice a day. The purpose ordinarily would be either to prevent the establishment of bacterial infection or to treat it, and it is well [218] indicated in this case.

Q. Will you comment on the subsequent notations?

(Testimony of Dr. Howard L. Cherry.)

A. Next, it says "M.S.," which is morphine sulphate, given every four hours for pain. That, again, is administered for the pain that would have been associated with this fracture.

The next is "C.B.C.," which means a complete blood count which had been done, type and cross-matching, which means to find a compatible blood to be given for blood transfusions when ordered. It simply means to cross-match it and see that it is ready if needed.

Q. Why would a blood transfusion be needed?

A. Why wouldn't it?

Q. Why would it?

A. This man had sustained severe injuries. At the time he came in he was examined apparently, and the possibility of him going into shock was considered, and blood was ordered in case he did, and in case he needed it. Those are standard, excellent practices.

Q. You have examined this record previously?

A. Yes.

Q. Did you find in that record that blood transfusions were ever made?

A. I did not find that it was ever made. I did not find that there was any reason whether it should have been given. [219]

Q. Is the morphine sedation for pain?

A. Yes.

Q. There is another indicated, sedamyl.

A. Sedamyl is a proprietary drug. It does not

(Testimony of Dr. Howard L. Cherry.)

happen to be one I have used or am familiar with, but I believe it is a sedative.

Q. Would it indicate that would be for pain, also? A. Yes, for pain.

Q. Deprapanex, 4 cc.

A. Deprapanex is extracted from the pancreas and it is given for the purpose of keeping the blood vessels working, increasing the circulation. It is a rather general drug. It doesn't do any harm and maybe it will help sometimes.

Q. What would be the specific reason for the use of Deprapanex?

A. My thought is that the thought going through this doctor's mind was that he wanted to keep the circulation as good as possible in this leg.

Q. That would be on account of a circulatory condition existing in the bone fracture, the site of the fracture?

A. The circulation condition in this area, which is critical anyway, a critical area, and anything you can do to help the circulation certainly would be worth doing.

Q. What do you mean by a "critical area"?

A. It is quite a subject, quite complex. When we see [220] fractures over the body, we know from past experience that some of them will heal no matter what you do, almost, and with others you have to be meticulously careful in order to get them to heal.

One of the places that we regard with the greatest care is the junction of the middle and lower surfaces

(Testimony of Dr. Howard L. Cherry.)

of the tibia, because of the circulatory problem involved. The circulation in the upper or around the upper tibia is excellent and the circulation surrounding the lower tibia at the ankle joint is very adequate.

The circulation into this one particular area of the tibia has to come quite a ways, and is supplied with relatively small and few blood vessels. Therefore, we should take special precautions to preserve the circulation in that particular area.

Q. If you will return to the doctor's order sheet, 6/10/52, there is a notation, "Light diet" and "Fluids."

(At 12:40 p.m., a recess until 2:00 p.m., was taken.) [221]

(Court reconvened at 2:00 o'clock p.m., July 22, 1954, pursuant to recess, and further proceedings herein were had as follows:)

Direct Examination

By Mr. John D. Ryan:

Q. Doctor, I believe I was asking you to look at the doctor's order sheet of the Physicians and Surgeons Hospital when we recessed, the order sheet as to 6/10/52. On it is indicated "Light diet," and then "Fluids ad lib," and then "Return flow," and so on.

Will you indicate to us the significance of that medication?

(Testimony of Dr. Howard L. Cherry.)

A. Light diet is food that is easily digested and that he would be able to take. "Fluids ad lib" means he should have such fluids as needed.

Q. What is meant by "Return flow p.r.n."?

A. That is an enema that is given to prevent the belly from becoming distended, or to help if it does become distended.

Q. There is additional medication indicated on June 10, 1952. Is there any essential change in medication there?

A. There is a change in the type of penicillin, from one brand to another but, essentially, it is the same thing, and is the same dosage.

They have increased his sedation a little bit, [222] but nothing remarkable about that order.

Q. I notice on 6/10 there is an indication of "Catherize p.r.n., 8 to 10 hours." Will you read that?

A. "Catherize p. r. n., 8 to 10 hours." That means that if he was unable to urinate, there was a standing order for that.

Q. Does that indicate that it was done?

A. This order does not indicate that it was done. It is merely an order to the staff, that if it was necessary that they could do it.

Q. Would you be kind enough to look at the part of the doctor's order sheet and inform us whether there has been any essential change in medication or treatment of the case down through June 11th?

A. On June 11th, they stopped the rather heavy

(Testimony of Dr. Howard L. Cherry.)

sedation for pain. They gave him some fluids. That is essentially all.

Q. What would be the significance of giving him fluids?

A. Well, that is a rather small amount of fluid, actually. Usually a patient requires about 3,000 cc. of fluids a day. This ordered 1,000. From the order I would assume he was taking some, but he needed to supplement it because he wasn't taking enough.

Q. Is there any significance about the change in sedation?

A. The assumption on my part is that he was becoming rather [223] heavily sedated, and they didn't want to keep him——

Q. I notice on the bottom of the sheet, June 11th, there is some entry to this effect: "Omit sedamyl, while markedly sedated." Will you explain what that means?

A. It says "Omit sedamyl while markedly sedated." Sedamyl is a sedative and apparently from this order he was quite far sedated, and they wanted him to quit, so they left it out.

Q. Is any of this treatment related to the condition of shock?

A. The only thing here I can see that is related to shock would be to type and cross-match the blood. It was not used. I don't think shock was ever treated as such, by these orders.

Q. If you will turn to the next page, Doctor, 6/12/52, 7:45, would you give us the significance of the entry there?

(Testimony of Dr. Howard L. Cherry.)

A. The order reads: "Give Dromoran, 1 cc. by hypo now," which was 7:45 in the morning, and "Allow patient to take four Empirin No. 3 tablets along."

Apparently that was when they were getting the ambulance, but that is rather light sedation; that isn't very much.

Q. Is there any entry indicating a continuation of the fluids?

A. No, there are no fluids ordered that day. [224]

Q. Would you turn to the temperature chart in the same exhibit, Exhibit No. 1, for the morning of June 10th? Would you explain the significance of that?

A. Well, there are two graph markings here—three. The top one on the original is red; it does not show in the photostat. That is his pulse. The normal pulse is around 80, something like that. The rate of pulse rose to about 110.

The next line has "R" written on it, and that is his temperature. The temperature was practically above 100 the last times it was taken.

Then, at the lower portion of the chart is "Respiration," and the respiration rose to 24.

Q. I notice you say the upper line indicates the pulse rate? A. Yes.

Q. Tell us what that means as to the times at which the various pulse rates are recorded?

A. At the time he came in, his pulse was 86; at the time of the first reading, at the time it was first

(Testimony of Dr. Howard L. Cherry.)

measured—that would be at 6:00 o'clock in the afternoon of June 10th—his pulse recorded 86.

Q. Before you proceed, will you tell us what a normal pulse is?

A. A normal pulse runs in the range of 70 to 80. [225]

Q. Yes.

A. And this is about 86, which was not a significant rise. Then it goes up to 110, which is more rapid than normal. It is not dangerous, but it is a significant rise.

Q. What is the significance of that rise, related to what?

A. That means he is sick; that is all it means. If it were extremely high, it could mean he had bled out or something like that, but that is not remarkably high; it is about what you would expect for that kind of injury; nothing unusual about it.

Q. You were then going to remark on the temperature.

A. The temperature was 99 when he came in and it goes up to 100. Again, that is approximate. There is a little rise in temperature there which you would expect to have occur after an injury. It does not mean his condition is critical or that he has septicemia or anything of that nature troubling him. It is a fairly normal rise in this type of injury.

Q. Would the pulse rate have any indication as to the condition of shock?

A. In the presence of shock, severe shock, the pulse rate would be very rapid, but the most signi-

(Testimony of Dr. Howard L. Cherry.)

ficant time is early. It was not very high and never did go high enough to be particularly significant.

Q. Would you explain to us the significance of temperature [226] as to the question of shock?

A. It has no relationship whatsoever, as far as I am concerned.

Q. I notice, also, the red line runs from the word "urine." Can you explain that, at the bottom of the page?

A. There is nothing in the urine—that red line does not indicate the urine at all. However, the blood pressure is recorded there as being 140 over 88, which essentially rules out any shock being present. That is a normal blood pressure.

Q. With reference to the question of blood pressure, would you explain that?

A. Well, first of all, in shock the most indicative of anything we can measure is blood pressure.

Q. Would you explain why a blood pressure is indicative of shock?

A. Shock is quite a complicated picture, but essentially it is a collapse of the circulation, and the thing that happens is that the blood vessels relax and, instead of the heart pumping blood into these blood vessels, these vessels relax and the pressure goes way down, and the heart beats rapidly, trying to maintain the pressure; but in lay terms I think "collapse" is about as good a term as we can compare "shock" to. It is quite intricate, but the essential factor in it is marked reduction of blood pressure so that the [227] circulation is not maintained normally.

(Testimony of Dr. Howard L. Cherry.)

Q. Blood pressure would go down, then, in the presence of shock? A. Yes.

Q. Would you look at the bedside notes in the same exhibit and would you read to us the blood pressures that were taken and the times at which they were taken, as recorded in the bedside notes of the record of the Physicians and Surgeons Hospital?

A. June 10th, the first blood pressure I see noted is taken by a nurse on the floor, presumably at 3:00 o'clock. His blood pressure is recorded as 140 over 88.

Q. That would be the one you have just explained?

A. I think another point that might be of some interest is that apparently nobody was interested enough in or was sufficiently afraid of shock to order the blood pressure taken. If you are afraid a patient is going into shock, you order the blood pressure taken every half-hour. It was not in the order sheet and they didn't take it until 6/11/52 at 4:45; that is the next one I see here, so apparently nobody was much concerned or was much afraid he was going to be in shock.

The next blood pressure is 4:45 p.m., on June 11, 1952, and that again is a normal blood pressure, 130 over 90.

Then, at 8:00 o'clock on the evening of June 11th [228] it is 140 over 90, and that is all the blood pressure recorded.

Q. Is there any significant change in any of these

(Testimony of Dr. Howard L. Cherry.)

blood pressures indicative of shock? A. No.

Q. Returning to the bedside notes, Doctor, that you have read previously, is there any significant information in the bedside notes that would vary your interpretation of the medication given in the doctor's order sheet?

A. As far as medication goes, the nurses have carried out very correctly the medication ordered by the doctors, and that is recorded, if I understand that is what you mean.

Q. Yes. Beginning under the word "Remarks" it reads: "Admitted to 115 per stretcher," on the first page of the bedside notes. A. Yes.

Q. Could you read that for us?

A. "Admitted to 115 per stretcher, X-ray. Put to bed in hyperextension."

Hyperexten means with the back extended in this manner (illustrating). The reason for that is to protect the fracture of the spine.

Q. How does that protect it?

A. It keeps pressure off the compression fracture of the spine. [229]

Q. That is by arching? A. That is right.

Q. Going on down under "Remarks," can you read the next entry?

A. Yes. "Drs. Schneider and Stalder here"—that is at 3:00 p.m., June 10th. Then the nurse signs her name "E. R. Mueller, R.N." That is the last note written on the date of admission.

Then on 6/11 we find "Left leg elevated on two

(Testimony of Dr. Howard L. Cherry.)

pillows," and a notation of medication for pain. Then at 5:30——

Q. I notice the date is June 10th?

A. This is June 11th now.

Q. This is June 11th?

A. June 11th starts about the eighth line down under Mueller's notes.

Q. To the left there is the date June 10th, and then the hours as they are going down. Are you talking about 4:15?

A. I may be reading this wrong, but this looks like "3/11." Maybe that is something else. Yes, it is. I don't know what these marks do mean. It looks to me like "3" and then a dash and then "11." On the eighth line it reads: "Left leg elevated on two pillows."

Q. Explain the significance of that elevation?

A. The leg is elevated to keep it from swelling and to [230] keep it from bleeding. That is standard. That is all.

Q. Elevated on pillows? A. Yes.

Q. Going down further into "Remarks," you see "Dromaron for pain." A. Yes.

Q. Would you explain what Dromaron is?

A. Dromaron is a sedative, an analgesic.

Q. At 5:00 o'clock on the afternoon of the 11th I notice he is sleeping. A. Yes.

Q. Is there any further significance noted under "Remarks"?

A. This patient had been very well watched by the nurses, I might say. They have a note there for

(Testimony of Dr. Howard L. Cherry.)

every 15 minutes to a half-hour. I see here "Crying, in pain" at 5:30; at 5:45, some more Dromaron. That is an hour and a half later. At the same time he refused any diet. At 6:30 he was sleeping, and at 7:00 he was awakened by the family. He apparently had visitors. At 7:30 he was having some pain and at 8:00 o'clock he had some tea. At 9:00 o'clock he had penicillin and Deprapanex.

Q. Explain the significance of the penicillin and the number of units given.

A. That is a good, substantial dose of penicillin, 400,000 units. It is given twice a day. That is a standard dose. [231]

Q. Deprapanex, you have explained that previously.

A. I explained that before. It is given for the purpose of improving the circulation.

Q. I notice here a notation "Some bleeding from left leg" on the last page of the sheet for June 10th. What is the signifiance of that?

A. It depends on what is around this leg. You would expect in a wound that has not been closed that the wound would bleed, and the amount of bleeding is dependent on what it is bleeding through. If it is a thin dressing, a small amount of blood might bleed through; but if it is a thick dressing, it takes more. Just from that note I can't tell how much bleeding was involved.

Q. If you will refer to the next page of the bedside notes, the first note there says "Has no desire to void." Is that of any particular significance?

(Testimony of Dr. Howard L. Cherry.)

A. He has been in the hospital since 3:00 o'clock and it is now 9:00 o'clock. There is no great significance to it. It just means he does not have to empty his bladder. He has not taken enough fluid to distend it. I would not attach anything very profound to it.

Q. As you go down under "Remarks," please explain the significance of any further remarks.

A. At 10:00 o'clock he is asleep. At 10:20 he was given some Dromaron again for pain in the back. [232]

At 10:30 he was catheterized and voided 300 cc. by catheter; nothing wrong with it. That is about a little over a cup; wouldn't be much distended if that is all he got.

Q. Have you found any significant evidence of ileus up to this point in the bedside notes of the doctor's orders?

A. I have not yet. I might make a remark there.

Q. Yes, if you will.

A. That nurse wrote beautiful notes, and the doctors wrote almost nothing. Ileus is something that the doctors would notice, and that notice would not appear from the chart. I can't say one way or the other.

Q. Would you anticipate its presence at this stage?

A. I would expect an ileus in a fractured back to occur usually in about 24 hours.

(Testimony of Dr. Howard L. Cherry.)

Q. In a fractured back of the type you have seen in the X-rays here?

A. Yes, that is the common thing.

Q. Would you go further down under "Remarks" then, Doctor?

A. Then, at 12:00 o'clock midnight there is a note, "Seems to be sleeping quiet."

At 3:40 he was given Dromaron for pain.

Then, at 6:00 o'clock in the morning, when patients are awakened in a hospital for some reason, the nurse states that he was given his early morning care which [233] consists of washing the face and hands, and letting them wash their teeth or something like that.

Q. At this point, at 6:00 o'clock on the morning of the 11th, is there any evidence of shock in the information given by these notes?

A. There is nothing in the information in the chart; there is nothing either way. He is alert or awake, and there is no blood pressure taken. His pulse is within reason, but I can't say Yes or No from the evidence exhibited in his chart.

Q. Would you go through the "Remarks" and the directions given down through June 11th?

A. Then, after 6:00 o'clock, the notes state that he had a light diet and ate fair, which would indicate—that would indicate that he did not have an ileus. You don't eat when you have an ileus. Apparently he was cooperative at that time and able to eat.

(Testimony of Dr. Howard L. Cherry.)

Then he had Deprapanex again, and then had a bath, and was given penicillin.

The note is "Some bleeding showing through dressing," and "Drs. Stalder and Craig in."

At 9:05 he had another hypo for his pain. At 9:30 he had some more sedatives and the note reads: "No desire to void. Has been perspiring."

Then, at 11:00 o'clock: "Dr. Leonard saw [234] patient."

At 12:00 o'clock the note reads: "Ate very little."

At 1:00 o'clock he was given empirin for pain, and there is a note, "No relief from empirin."

Then at 2:00 o'clock the note reads: "Some bladder distention," and "Unable to void."

Q. Will you explain the significance of that?

A. That means the bladder was full and he had a desire to uninate but couldn't urinate.

Q. How can that be relieved?

A. Sometimes they can do things to help them urinate themselves; sometimes they have to be catheterized.

Q. Go on down through "Remarks," then, please.

A. Then at 3:00 o'clock the patient is sleeping very soundly and perspiring; given a light diet, and the nurse states she is unable to rouse patient. That is at 4:30.

Q. Is that related to his sedation?

A. He has had an awful lot of sedation, I would say.

Q. When you say "an awful lot of sedation,"

(Testimony of Dr. Howard L. Cherry.)

would you explain the significance of that, what you mean by that?

A. Ever since he has been in there he has been getting something for pain or rest every two or three hours.

Q. Has there been any other treatment given to relieve pain evidenced here? [235]

A. There has been Dromaron, Sedamyl, empirin and codeine.

Then the blood pressure is recorded again, as mentioned before, at 130 over 90, and he passed 350 cc. of urine apparently by himself—no, it is catheterized again. 4:45, catheterized, 350 cc. urine. A note is made that there is still some bleeding through the dressing and the urine is dark in color. The significance of dark-colored urine is that it is concentrated and that he probably did not get as much fluids as might have been ideal.

Q. How would fluids be administered to a man in this condition?

A. The nurse can give fluids by mouth, by element of persuasion, up to a certain point. If he is unconscious, they would have to be given intravenously.

Q. What do you mean by intravenously?

A. By tube and needle. You put this in a vein in the arm, usually.

Q. At this time the patient, by the record, seems to be sleeping?

A. He seems to be. The note says the nurse

(Testimony of Dr. Howard L. Cherry.)

could not rouse him. That means just plain sleeping. He is quite sedated, apparently.

Q. You would expect a man with this amount of sedation to be pretty much in a stupor?

A. Yes. [236]

Q. Is there any indication that intravenous fluids were given to the patinet?

A. I haven't found it yet. No, there have been no intravenous fluids up to this point.

Q. I notice it says, "Some bleeding through dressing." That has no significance?

A. I don't know whether that is the same bleeding he had before or whether it is a new bleeding. Usually, when you see a note like that you think it is still bleeding. Again, I can't tell you how much. It depends on how thick the dressing is or how tight it was put on.

Q. Further on in the exhibit, if you will look to the out-patient record, I think about the last page——

A. Is it a part of the same chart records?

Q. The last page in the same exhibit under "What Was Done." You see the notation "Compression dressing to left lower leg." Would that have any significance as to the size of the dressing, with relation to the bleeding?

A. Again, I don't know what they call a compression dressing. A compression dressing I put on would be quite thick and it would take an appreciable amount of bleeding to bleed through, but I

(Testimony of Dr. Howard L. Cherry.)

can't tell what they call it. Some people use a little one and others use a big one. I use a big one.

Q. Then there is no uniform size of a compression dressing?

A. That is right. If they want really to immobilize this, [237] they use a big one. I assume that they had a big one, but I don't know.

Q. Going further down through these bedside notes under "Remarks" I notice here, "Side rails on."

A. Those are rails that are put on the sides of the bed to keep the patient from falling out of bed. The significance of that is, it would seem to me, with his sedation they were afraid he was not well enough to control all his actions and that he might get out of bed or fall out of bed or climb out of bed. These are just side rails on the edge of the bed.

Q. I notice the notation "Patient somewhat restless." Would that indicate a reason for the side rails?

A. Yes, that would go with the reason for the side rails.

Q. Is there anything further in those remarks that you feel is of significance that would alter the course of treatment, your impression of the course of treatment which was given?

A. I am not sure what you are asking for in your question, but it does not look like it is a patient that is ideal to go for a long trip.

Q. Why do you say that?

A. Well, he is not conscious a good share of the

(Testimony of Dr. Howard L. Cherry.)

time; he is restless and threshing around. He is not in shock, but his condition does not look like it is very good. They still have to catheterize him to get him to pass his urine. [238]

Q. Would moving the patient have any effect on the condition of the back?

A. A patient could be moved with a fractured spine. If it is done right, I don't think it will do any damage. If he were in a hyperextension position, it could be done. However, it would be rather an intolerable thing for a patient to stand and it would be far more analgesics than we like to give them ordinarily, to try to move a patient with an injured back 200 miles.

Q. By moving the patient, you mean to take him in an ambulance, as this man was, to Seattle?

A. Yes.

Q. What would be the effect of this movement upon the leg?

A. If the leg were perfectly immobilized in a cast, or something like that, he could be moved like that without any effect. However, if it were not well immobilized, it would increase the deformity, and it would impinge on the soft tissues which are already critical, and it certainly would not help.

Q. What do you mean by "perfectly immobilized"?

A. "Perfectly immobilized" to me would mean that the fractures are reduced in good apposition and held with some sort of device, either internally

(Testimony of Dr. Howard L. Cherry.)

with screws or a plate, or externally with a good cast, for a trip like that. [239]

Q. What would you describe an adequate cast to be?

A. A good cast would be some padding around the leg and then to enclose it in plaster, or the equivalent of that, but it should be done so that it does not pinch on the fracture and also so that it holds the fracture, so that it will not move from its reduced position.

There is one other standard and excellent way of immobilization or moving the patient that has been used in war, in practice in connection with the war, particularly, and to a considerable extent in civilian practice, and that is the Thomas or so-called Thomas splint in which the leg is bolted on. That would be a satisfactory method except, again, that would be quite uncomfortable.

Q. Would you say that a compression dressing extending up above the knee and over the injured area, involving the use of a Yucca board splint which would be 24 inches long, would be of sufficient immobilization or would constitute sufficient immobilization to permit the movement of the patient under these conditions?

A. It would be far from ideal. I think, unless there is some emergency, it is not ideal for transporting a patient with this type of fracture.

Q. By being far from ideal, do you mean resultant danger to the patient?

A. The danger in this stage is that of damaging

(Testimony of Dr. Howard L. Cherry.)

the tissues, [240] as well. You must do everything you can to preserve the tissues so that they will heal well, and any moving around or dislodging of the fracture fragments or pressure on the skin or tissues will make the tissues that much worse when it comes to healing.

Q. Would that affect the circulation, Doctor?

A. Yes, it could.

Q. In what manner would the circulation be affected?

A. The circulation is affected by this pressure and movement of the small blood vessels which go into the particular area involved, the blood vessels feeding down to this area where the bone fracture existed. Every bit of tissue in the body has blood vessels in it.

Q. You said that having a Yucca board splint approximately 24 inches as a part of the compression dressing, a fairly heavy compression dressing, would be far from ideal. What do you mean by that? Did you mean that there would be risk?

A. Yes. I do not feel that is adequate for transporting a patient.

Q. Would you turn to the out-patient record in the same exhibit? Have you got that, Doctor?

A. Yes.

Q. It indicates he was brought in by ambulance and his condition diagnosed as a compound fracture of the left lower leg, and it indicates "Consultant: Dr. Craig" and "Attended [241] By" and then it says "Schneider and Stalder." A. Yes.

(Testimony of Dr. Howard L. Cherry.)

Q. Would you read the statement of what was done?

A. "Morphine gr. 1/6 hypodermically for pain at 1:30 p.m. Compression dressing to left lower leg. Abbocillin, 800,000 units; catheterized, specimen to laboratory," and then the patient was sent to X-ray and it reads: "Admitted to Room 115."

Q. Can you give us the significance of that, or state what treatment was given, from this report.

A. From this report, this fracture was not treated. I mean the report does not say that it was treated. All the report says is that a compression dressing was put on.

Q. Would you say from the thorough reading of the report that you have made, and previously, of what had been done up to this point, and considering his other injuries, that the compound fracture of the lower third of the tibia had been properly treated? A. I would say no.

Q. Why do you say that, Doctor?

A. Any compound fracture is an immediate emergency, and anybody who ever went through medical school should know it. We spend hours and hours trying to teach everybody that point. This is a compound fracture and it is a severe thing and it involves an area where there is notoriously poor [242] healing, and if any compound fracture is an emergency this would be a great emergency.

The proper treatment, in my opinion—and I believe it is shared now universally—is that this wound

(Testimony of Dr. Howard L. Cherry.)

should be very carefully examined, carefully cleaned, to its depth, reduced if possible and the wound closed. If there is any foreign material anywhere, it should be removed. If there is devitalized tissue anywhere, it should be removed.

The time element is of extreme importance. We figure that what we call the golden time in the treatment of fractures, compound fractures, is from six to eight hours.

If we get a fracture at 3:00 o'clock in the morning, we get out of bed and we come and call the surgeon and anesthetist and X-ray technicians, everybody—it takes about ten people—and that fracture is treated just as soon as we can do it, in order that we can treat this patient properly, because when contamination gets in there, you get danger of infection and of impaired healing, and we figure that the time is from six to eight hours, the earlier the better, but after that length of time the tissue is damaged and cannot heal as well as it could before that.

When it goes 24 hours, ordinarily we would not even close it because there would be danger in closing the wound.

The most striking thing about this whole thing to me [243] is how people practice medicine and don't know that or don't practice it; that is, early, adequate cleaning, reducing and closing and fixation of the compound fracture. You would not expect everybody certainly to be able to do it adequately, but I would expect anybody, a nurse or anybody, if

(Testimony of Dr. Howard L. Cherry.)

they didn't know how to do it, I would expect them to know what should be done, and, if they can do it themselves, why, then, go ahead; if not, get some help.

The criticism I have, after carefully studying this, is that, not that they wouldn't know how to do it but that they did not, for some reason, either do it right then or call someone in who knew how to do it.

Mr. Harr: We object to that type of testimony, your Honor, because the doctor is testifying from what he says shows in the record, and the testimony has been otherwise. If Counsel framed his question around what the record shows, then I think the doctor would be perfectly qualified to answer it.

I am objecting to this entire line of testimony anyway on the ground it is improper and irrelevant.

The Court: He may continue. Proceed.

Q. (By Mr. John D. Ryan): In addition to the information you have gained from a reading of the record in the courtroom and at your office, the testimony shows here that when this man was brought from his home in Portland, Oregon, [244] about 12:00 or 12:30 on the afternoon of June 10th, 1952, he was taken by ambulance to the Physicians and Surgeons Hospital and taken to the emergency room there, and at that time there was a protrusion of the bone through the leg, and there was a compound fracture of the lower third of the left tibia, which you have seen.

In the course of emergency care by Dr. Schneider

(Testimony of Dr. Howard L. Cherry.)
he washed the wound externally with an antiseptic or saline solution and applied a compression bandage which was described as one which extended above the knee of the patient, and also that it was his recollection, Dr. Schneider's, that he applied a Yucca board splint of approximately 24 inches to the lower left tibia of the patient; and that the patient was then X-rayed—or he may have been X-rayed prior to the placing of the splint—and was put in a ward of the Physicians and Surgeons Hospital with his leg elevated on pillows, as indicated in the record which you have read, and that the leg was not further seen by any person at the Physicians and Surgeons Hospital, being bandaged for the entire time, from approximately 1:45 or 2:00 o'clock on June 10, 1952, to and including June 12, 1952, at about 8:00 o'clock, when he was discharged to be sent by ambulance to Seattle, Washington, for treatment at the U. S. Marine Hospital.

There was no further treatment directly to the wound site. [245]

Would you deem treatment of that type to be the proper practice for the treatment of a compound fracture of the tibia, of the lower third of the left tibia, considering also the other clinical findings which you have had opportunity to refer to, in the City of Portland, Oregon, on June 10, 1952?

Mr. Harr: Objected to, your Honor. I do not believe the facts are set forth quite accurately, in that he did not call attention to the fact that the wound was abraded, that there was a considerable

(Testimony of Dr. Howard L. Cherry.)

area of abrasion, and lacerated areas. There were two lacerations, one an inch or an inch and a half long and another shorter laceration; and then a mild antiseptic solution was applied to the area surrounding the fracture site, and that the wound was irrigated with a saline solution and, following that, a compression bandage was applied, and that bandages were wrapped around it until the leg was at least 10 inches through from the knee down to the ankle, and then a splint was applied.

I do not believe the hypothetical question is complete.

It is objected to for another reason, and that is as to what Dr. Cherry would consider to be proper or improper. If he is basing it on what specialists would deem proper, that is one thing.

The Court: This is a hypothetical question and has been [246] propounded. You can develop your theory on cross-examination. The objection is overruled.

The Witness: Your Honor, may I make a comment? I don't know if it is proper, but everybody knows this, that I have very thoroughly studied all the charts; I have read and studied the reports of the physicians; I have talked to the patient. I have deliberated this whole question in my mind for a matter of weeks. I might also state it is one of the most distasteful things I have been called on to do, to criticize someone else's work. We very much dislike doing that, but to the question Mr. Ryan asked, including the other statements made, I still have to

(Testimony of Dr. Howard L. Cherry.)

say that the treatment was not correct; it was not what he should have obtained; that if the doctor who saw him did not know how to treat it he should at least know it was beyond his scope or capacity and should have called in some other doctor to treat the patient.

The answer to the hypothetical question as put is that in my opinion, under these circumstances, this patient did not get good care in his initial treatment.

Mr. Harr: May I inquire the scope of the witness' answer, whether or not this answer goes to the first emergency treatment by Dr. Schneider or whether it goes to the 40 hours he was in the Physicians and Surgeons Hospital?

The Witness: May I answer that? [247]

Mr. John D. Ryan: It is out of order, but go ahead and answer it.

A. I would say if there had been only one gross error in his treatment, I would say the lack of adequate immediate care, nothing else, is of enough significance to be of extreme importance to me. I think there may have been a little more judgment used in some of the other things, but it does not compare in what is going to happen to this man over the months and years ahead, does not compare to this one error of not getting adequate care early.

Mr. Harr: May I ask one question, your Honor, so I will understand the doctor? Does that refer to Dr. Schneider's immediate emergency treatment?

The Court: He is talking about the period of

(Testimony of Dr. Howard L. Cherry.)

five or six hours. He said he would not let it go more than five or six hours.

Mr. Harr: He said immediate care.

The Court: He said, just ten minutes ago, that five to six hours was the time within which he would assemble the people necessary to give him the proper attention, and that if it was at 3:00 o'clock in the morning he would get them out of bed. Is that what you are talking about?

The Witness: Yes, your Honor.

Q. (By Mr. John D. Ryan): Doctor, under the circumstances under which man was suffering, what would you say would be [248] the result of the failure to treat this man within six to eight hours?

A. The result we might expect would be a great delay in healing this wound, and that might be in the form of infection—that is the thing we are scared to death about all the time—or it might just delay healing due to poor nourishment of the tissues around it.

Q. What was the result of that, from your observation of the treatment accorded this patient?

A. In observing this case, the records I have seen, I think the number of months of treatment and the number of operations and days of hospitalization and pain—I think it was very greatly lengthened.

Mr. Harr: We object to that, your Honor. There is no showing that the treatment that was made necessary seven or eight months after the accident was

(Testimony of Dr. Howard L. Cherry.)

attributable to the first 40 hours that the man was in the hospital.

The Court: He just said it was. You can dispute it, of course, but it may stand.

Q. (By Mr. John D. Ryan): Doctor, in connection with a compound fracture of the lower third of the left tibia, you have stated that there was a possibility of infection. Do you deem the site of an exposed wound of that type to be infected?

A. That is where the great importance comes in of treating [249] it within six hours. We do not consider it to be infected. Rather, we start out alerted, not that there is danger for bacteria to really contaminate it and set up an infection in that length of time, but in that length of time it can be cleaned to a degree where we would expect to close the wound and have it heal without infection. After that time, you have lost that opportunity, and you must consider that the bacteria——

The Court: Mr. Ryan, wind this up so we can conclude the cross-examination this afternoon.

Q. (By Mr. John D. Ryan): Doctor, have you familiarized yourself with the hospital records of the United States Marine Hospital regarding the treatment of the plaintiff, Amos Morin?

A. Yes.

Q. You recall he had an operation, a closed reduction, on the 12th of June at 3:03 p.m.?

A. Yes.

Q. Would you describe what that operation was?

A. I might comment that from the record the

(Testimony of Dr. Howard L. Cherry.)

record is beautiful, the record from the Seattle hospital. As far as I can tell, their care was very excellent.

This man arrived at Seattle on the 12th, I believe, unresponsive, comatose. They had taken him, in an hour or two hours, into surgery—he was still comatose—and given [250] him a spinal anesthetic. They very carefully debrided, cleaned and scrubbed this wound and closed the wound. It was very excellent, fine treatment, and if that had been done in the first few hours following his injury, it would have made the difference between a good, clean healing of the leg and one protracted over many months, healing protracted over many months.

Then the next treatment was some days later, when this original wound was fairly well healed; it became obvious to them that they would have to open this fracture and stabilize it with a bone graft and a plate. Knowing how I would feel at that time, I would be reluctant to do it, but it was necessary so that they did it. They put the plate and screws and bone graft across this fracture, and then they nursed it along. The wound was slow to heal. It gaped a little for quite a while, but finally it did heal almost entirely, an dthat is the time when he came down to us.

As I said in connection with these charts, the only entirely, and that is the time when he came down they might have taken a couple more X-rays during the time he was up there.

(Recess.)

(Testimony of Dr. Howard L. Cherry.)

Q. (By Mr. John D. Ryan): You say that the only comment you had to make of the Seattle treatment, after your review of the [251] record, was that they might have taken some additional X-rays?

A. Yes. That is not a very severe indictment.

Q. Doctor, would you tell us what you deem to be proper treatment of this type of injury?

The Court: You have stated that over and over. Come on, now, and wind up your examination.

Q. (By Mr. John D. Ryan): Would you explain what a debridement is?

A. A debridement is the careful cleansing and removal of all foreign material.

The Court: He has covered that over and over again. Ask him whether the treatment was responsible for the man's condition.

Q. (By Mr. John D. Ryan): Was the treatment rendered responsible for the present condition of Mr. Morin? A. Yes.

The Court: What is your prognosis in this case?

The Witness: The prognosis of this case is that he will have a deformed leg to a certain extent; he has osteomyelitis which may recur—it has a tendency to recur. He has marked tenderness and pain in his foot and ankle which of course will decrease with the years but will probably be present——

The Court: Cross-examine, Mr. Harr. You can come back [252] for redirect if you have something further to ask him about.

(Testimony of Dr. Howard L. Cherry.)

Cross-Examination

By Mr. Harr:

Q. We will all agree that there are many causes of osteomyelitis. A. There may be.

Q. You know of more than one, don't you?

A. I don't know what you mean, because osteomyelitis—the cause f osteomyelitis is bacteria. That is the only cause I know of.

Q. It can come through the wound, of course?

A. It can come through any open wound.

Q. It may come through the bloodstream, of course?

A. There is a type of osteomyelitis—well, it may be a type of osteomyelitis—that comes from the bloodstream but doesn't come from the fracture site. I think I could very accurately say that the chances of this coming through the bloodstream are absolutely nil. I don't think that can be considered here.

Q. If there were an infection in the system, a focal infection, isn't that apt to hit a vulnerable spot, say, a fracture site, especially where there is poor circulation?

A. That is quite an involved question. I can say that there may be theoretically a remote possibility of it occurring [253] at the fracture site. I would also say that I have never known it to occur; I have never seen it and, in my recollection, I have never seen it in the literature, and I would say that pos-

(Testimony of Dr. Howard L. Cherry.)

sibility is extremely remote, while on the other hand you have a very obvious reason why it would occur in a compound fracture.

Q. For instance, from the time he left the Physicians and Surgeons Hospital in Portland—he was here about 40 hours, I guess—isn't it quite possible that the infection came from the wound or from some other source?

A. The wound was closed within a matter of a very few hours after he got to Seattle. The fracture was opened one other time. Of course, I can't say that it could not possibly occur—the fracture was opened one other time to graft it under sterile conditions. I cannot say of course it could not possibly occur.

Q. You said it was open when he came down from Seattle?

A. It was open, because pus was draining out of it; the bugs were going out, not in.

Q. Does that mean that was osteomyelitis simply because there was some drainage coming out?

A. No, I didn't say that.

Q. Was there osteomyelitis, Doctor?

A. There was osteomyelitis, very definitely, and I had specimens taken at the time I took the plate out. He had [254] soft tissue infection and possibly osteomyelitis before that.

Q. Did you, before you manipulated that leg in August, did you cause a culture to be made?

A. No.

Q. Would you have manipulated the limb in that

(Testimony of Dr. Howard L. Cherry.)

manner with an active infection, if this were a perfectly clean leg?

A. I would probably open it and operated it. Manipulation causes very limited disturbance. I considered, of course, his condition, and this manipulation that I did I don't believe would do any damage in the presence of an infection.

Q. Are you able to say that there was an active infection in there? A. There was infection.

Q. That was osteomyelitis?

A. I can't prove it was osteomyelitis at that time.

Q. Then did you take the risk of manipulating these bones without knowing whether or not it was osteomyelitis?

A. If there were osteomyelitis present, it would not hurt it to manipulate it to the degree that I did.

Q. Did you put down in the record, in your own hospital record at Providence or in your own office record, the fact that there was any osteomyelitis in that wound before you took him to the hospital in January? A. Not to my knowledge.

Q. What do your office notes say about that? Have you got [255] your office notes?

A. I don't believe I have them. Do you have those notes, John?

Mr. Harr: Would you hand the witness Plaintiff's Exhibit No. 12.

Q. That is your office record, isn't it?

A. Yes.

Q. What is your history there, as shown?

A. Well, I might explain——

(Testimony of Dr. Howard L. Cherry.)

Q. Read it, on the last page.

A. I might explain we don't take full histories in our office. We have a full history, an adequate history, in the hospital and we doctors don't duplicate what we put in the hospital records, as in our office records we have notations of the operations, the hospital findings, and so on, and then each time he comes in we add a note with regard to his condition.

Q. It seems to me that you have been rather critical, quite critical, of some of your fellow members in the notes that they keep. I would like to know why your record does not show that there is some osteomyelitis here?

A. May I call your attention to what the office record is? You have, not a photostat of one sheet, but you have a complete record which consists of probably 30 sheets.

Q. You are calling attention to the hospital records? [256]

A. I am calling attention—that is our office record. Our office record contains a carbon copy of all procedures that we do in the hospital and shows all the X-rays taken and some other things.

Q. Are these sheets you are holding in your hand duplicates of the hospital records?

A. Yes. Everything we have in our office pertaining to this patient, a good deal of it is from the hospital records.

Q. Let's look at your office notes. First, I see, "October 29th, X-rays left tibia." Is that right?

(Testimony of Dr. Howard L. Cherry.)

A. Yes.

Q. Then the next note is November 24, 1952, which note says: "Hurts bad at top of plate. Fracture is solid. Try heat to area." That is your record, isn't it? A. Yes.

Q. That is right, isn't it? A. Yes.

Q. There is no mention there, of course, of any infection. That is true, isn't it?

A. Nothing mentioned.

Q. Do you mention anything of any infection there?

A. I did not record it on this piece of paper.

Q. January 24, 1953, there is a notation: "Severe inflamed skin. To Providence."

A. So we understand correctly, it is before. [257]

Q. I believe that was before you took him to the hospital? A. Yes.

Q. February 11, 1953: "To Providence; abscess opened; plate out; wound dressed; black on edges." That is all your office note? A. Yes.

Q. Now, let's look at the Providence Hospital records. Let's first look at the Providence Hospital record pertaining to the closed reduction.

A. Which admission are you referring to?

Q. I don't know. It is August 24th, I think.

A. Yes, I have it.

Q. There it says: "Admitting diagnosis: Old fracture left tibia." Is that your diagnosis?

A. Yes.

Q. Then it says: "Old fracture left tibia with

(Testimony of Dr. Howard L. Cherry.)

malalignment. Operation: 8/25/52—closed reduction." That is the manipulation you did?

A. Yes.

Q. And then you applied a cast? A. Yes.

Q. "Complications, none," and "Infection, no." Is that right? Is that what your record shows?

A. I don't see that here. Maybe I am not looking at it.

Q. Look at the bottom. It shows Dr. J. M. Thorup signed [258] as attending staff physician.

A. Yes, but what are you referring to, do you know?

Q. I am referring to the Providence records.

A. Is that the front sheet, the diagnosis sheet?

Q. I don't know. It is a record made at the hospital.

A. That one marked or checked is "Hospital Infection." That means it won't become infected in that hospital. It refers to something that is operated in the hospital. It has to do with what was done in the hospital.

Q. Was there a bacteriological report made out showing any infection?

A. There was none taken.

Q. What? A. No specimen was taken.

Q. If a specimen is taken, do they always make a microscopic examination? A. As a rule.

Q. That is the purpose of it, isn't it?

A. Yes.

Q. If a specimen is taken?

A. It is not always done, but that is the rule.

(Testimony of Dr. Howard L. Cherry.)

Q. Let's look at the Providence admitting diagnosis on January 26th.

A. Would it be appropriate for me to mention that the wound is described in the chart, but you choose to read other pages? [259]

Q. The wound is described? A. Yes.

Q. You mean as of August?

A. Yes, this admission we are just talking about.

Q. Are you looking at the admitting diagnosis?

A. On the progress notes. This is the intern's writing; this is not mine. It would indicate the wound was not healed. That is in the progress notes dated 8/24/52. It is described as granulating.

Q. A granulating wound?

A. Yes. That means it had not healed but did have granulation present and the wound was not yet healed. Granulation is the process of attempting to heal and as long as there is granulation present the wound has not yet healed. That is in August. That sheet is some months before.

Q. Let's check the record at the hospital in January. Have you before you the January record?

A. Yes.

Q. There I notice you did diagnose it as "Osteomyelitis, shaft of tibia." Is that correct?

A. That is one of the diagnoses, yes.

Q. You made an incision and drained it, didn't you, at that time?

A. Yes, and removed the plate and screws.

Q. Before that on January 26th you say: "Right tibia." Is [260] that what you say?

(Testimony of Dr. Howard L. Cherry.)

A. Yes. That is wrong. It is the left tibia.

Q. Sometimes you doctors are a little bit hurried.

A. That is not written by me, not that I wouldn't do it, but that is not written by me.

Q. Then, on February 2nd, it says: "Removal of plate and screws, left tibia." A. Yes.

Q. Let's look at the operative record, January 26. You did make out this, did you not?

A. This record is typed on a machine.

Q. And you signed it? A. Yes.

Q. You say: "Pre-operative diagnosis, osteomyelitis right tibia." A. That is incorrect.

Q. You made a mistake here, didn't you? You have called attention to that before? A. Yes.

Q. That involves an incision and drainage. Is that what you mean? A. Yes.

Q. What you did was to open the wound a little bit and take out a small amount of pus.

A. This was about to break through. There was a considerable [261] amount of pus and it was about to break through, and we did open it up and the pus was drained, plus some flakes of bone.

Q. Then refer to the operative record covering the operation on February 2nd, the printed form, commencing with "What Was Done," and then it says, in parentheses," (Describe pathological findings, organs explored, incision, sutures, drainage and closure)." Then you filled this in: "Incision was made lateral of the plate over the lower third of the tibia, carried down to the plate. Four screws

(Testimony of Dr. Howard L. Cherry.)

and the plate removed. The bone was smoothed off. The wound was closed with interrupted silk sutures. Compression dressing of sheet wadding and tensor bandage were applied." A. Yes.

Q. That is signed by you? A. Yes.

Q. Will you look at the pathological report dated February 2, 1953? A. Yes.

Q. Would you read that, please?

A. "Gross Examination: The specimen consists of some irregular fragments of cortical bone, four screws 3.5 cm. in length and a metal plate 15 cm. in length." Then it says: "Diagnosis: Fragments of bone, screws, metal plate."

Q. Any infection? [262]

A. There is no indication one way or the other.

Q. Who signed that?

A. That has the typewritten signature, "A. Peter Crane," and is signed by Jeff Minckler, Pathologist. That doesn't determine whether there was infection or not. When pus turns up, you don't need to determine that by taking specimens. That was merely a record of what was done at that time. It probably would have been better if we had. If we had known it would come to court, we would have got cultures and some specimens.

Q. You, of course, knew that there was some drainage. You said the record shows the week previous you took out a small quantity of pus. That was apparently at the surface of the skin.

A. I didn't say a small quantity.

(Testimony of Dr. Howard L. Cherry.)

Q. You said it was going to force itself out, so you knew that there was some infection there?

A. Yes, I knew that there was infection.

Q. Did you find, in making your incision, that it was granulated down to the bone? Was there granulation there?

A. There wouldn't be granulation tissue down to the bone.

Q. Down to the bone?

A. I don't believe so. The pus was coming from the bone, and there were flakes of bone in the pus, indicating that there was an infection of the [263] bone.

Q. Flakes, what are they?

A. They are portions of bone.

Q. Were these little segments sequestered?

A. Yes.

Q. In other words, they were detached and away from the bone proper? A. That is right.

Q. The bone itself was pretty well healed, wasn't it? The healing was good?

A. In saying that it was healed there are two things we are concerned with. One is the healing of the fracture. I didn't take the plate off until it was healed. The infection was still there. There were little chips of bone floating in the pus.

Q. You did not find that infection in that wound when you first saw him in August?

A. In August we didn't get down to the bone. To the best of my knowledge, there wasn't pus present coming from the bone. The tissue was very

(Testimony of Dr. Howard L. Cherry.)

poor and it had not healed after months—it didn't have, to my knowledge, pus coming from the bone, if that is your question.

Q. If there is infection in a wound, a compound fracture site, how soon would that be apt to manifest itself?

A. Well, we have what we call a latent infection. That is, it can be in there right from the first—pus can be [264] pouring out of the wound and no healing going on at all or, it can be, as this case was, a low-grade latent infection that could flare up any time, and it could flare up from now on.

Q. That is your opinion now?

A. You asked me how it ordinarily showed up, and I was telling you how it can occur. Do you want to know in this case what I think it was? Is that what you are asking?

Q. Here we have a shin-bone and the bone is immediately next to the surface with a small skin surface.

A. Well, a very small amount of skin.

Q. If there is infection in that wound, it is right next to the surface, isn't it?

A. Actually, in this case if it were infected, I think it would be close to the skin, but it might be deep. I don't think it was in this case, but I say it could have been.

Q. The circulation was bad down there, you say. In any wound of this type, poor circulation, light circulation, might of course result in a bad result?

A. As far as circulation is concerned, this was

(Testimony of Dr. Howard L. Cherry.)

infinitely worse than if you, by some means, had obtained a primary healing of this wound. It is an area where we have to be very careful about the circulation.

Q. Let's go to the matter of the hospital treatment in Portland. It has been your testimony that the administering [265] of the Deprapanex was a measure to offset the ileus? A. Yes.

Q. To increase circulation? A. Yes.

Q. I think you said in your direct examination you did not use it, and you did not exactly know what it was good for.

A. The last time I used Deprapanex was, I would say, ten years ago; used it at that time to increase circulation in the leg. I am unaware that it is used for an ileus. It must be or they would not use it. We don't happen to use it. There are lots of drugs; we don't use them all.

Q. Isn't it good practice to first consider the patient's over-all general condition?

A. Yes, extremely good practice.

Q. Consequently, in the case of a man who has sustained an injury such as this man sustained to his back and to his leg, and considering the severe pain that he was undergoing, wasn't it good practice to take steps to guard against shock?

A. Surely.

Q. Wasn't rest and sedation a part of that?

A. No. I can answer that by saying no. Could I amplify that?

Q. Do you think that would be good practice?

(Testimony of Dr. Howard L. Cherry.)

Q. (By Mr. John D. Ryan): Go ahead and explain your answer. [266]

A. This man, as illustrated by the chart, was not himself. There was danger of going into shock. They used the means, which is excellent, of preventing shock, which is the use of blood. They had it ready, but the fact is that he did not go into shock or they would have given him blood. If he had started in shock, they would have given him blood. They didn't order it. They didn't order blood pressures taken as they would if he were going into shock or was already in shock. That can be determined in two or three ways.

Q. You are speaking, of course, now as an orthopedic specialist?

A. I would speak as a doctor. I do not think any doctor who treats people should treat on two standards, for I think a doctor should know his limitations. If he does not know that he can do it, he should know that he doesn't know. I do not criticize anybody in not being able to take out a brain tumor, but he should know, in the presence of certain symptoms, that he should call in somebody that could treat it.

Q. I know there is a lot of scuttlebutt and second-guessing, Doctor. When you have a young doctor, such as Dr. Schneider, who spent his internship in one of the leading hospitals of the United States, which had a very great number of emergency surgery cases, and he tells you, as he told us here and in [267] his deposition, about cleansing the

(Testimony of Dr. Howard L. Cherry.)

wound thoroughly, and that he put a dressing on, you would not be able to say that that man, being on the ground, after viewing the patient and knowing his condition, seeing him writhing in pain—do you not come along now and tell him, "Doctor, you did it wrong," that second-guessing is always best? In other words, isn't he——

A. Do you want me——

Q. Isn't the doctor the best judge of what to do in these cases?

A. Can I answer your first question—I think it was the first. The answer is Yes, and just as wrong as can be. What was your other question?

Q. I think the last question was: Isn't the doctor in attendance usually the best judge of what is to be done for the patient, having done the cleaning and applied the splint and provided the immobilization and the X-rays? Isn't his judgment usually the best to follow?

A. Now I would like to answer that. The position of a resident in a hospital——

Q. He is a qualified doctor. He is admitted to practice medicine.

Mr. Ryan: Just let him answer the question.

A. The position of a resident in a hospital is to cover emergencies, to inform the doctors as to what is going on and, [268] under their guidance, to do what the doctor says.

I don't know your Dr. Schneider. I don't know him when I see him at all, but anyone who had had adequate training and had seen compound

(Testimony of Dr. Howard L. Cherry.)

fractures should know that you don't treat them by wiping something over them and putting a dressing on them. The other part of that is that resident is not responsible for the case. It is not the resident's case; it is someone else's case.

Q. I know that.

A. And somebody else did not deem it important enough, if it was a compound fracture, to come up there——

Q. You are volunteering some information, now. Are you acquainted with a textbook on surgery——

Mr. John D. Ryan: There is contention in the pretrial order that both Dr. Leonard and Dr. Craig were informed of the existence of the condition. He is not volunteering testimony.

Q. (By Mr. Harr): Are you acquainted with a textbook on surgery by Christopher?

A. I know of the existence of Christopher's book. It is a general surgery book. I have not studied it particularly, but I know there is such a book.

Q. The part I am going to refer to pertains to the operative treatment of fractures, written by Paul B. Magnuson, Chairman of the Department of Bone and Joint Surgery, Northwestern [269] University Medical School.

A. Yes, I know him.

Q. I am reading from Page 708 headed "Choice of Time for Operation."

I am just going to read this and ask you whether or not you agree:

(Testimony of Dr. Howard L. Cherry.)

"It is fairly generally agreed among surgeons that the choice of time for operative intervention in cases of fracture is from five to ten days following occurrence. This gives sufficient time for the tissues to recover from trauma and for the blood cot to organize, and yet not sufficient time to allow callus to form. The swelling is less, and bleeding at operation is less if this rule is followed. It also permits healing of abrasions in the neighborhood of the fracture."

Do you agree or disagree with that statement?

A. He is talking about simple fractures. If you read the rest of that, you will find that refers to a simple fracture. We are talking about a compound fracture. If he discusses compound fractures, he will not say that. As to simple fractures, that is very excellent.

Q. I will read as to compound fractures. He says on Page 704:

"Shock and hemorrhage are frequently grave and [270] attention must be devoted to them first."

Is that proper?

A. Absolutely. It takes up to an hour or two hours to replace blood and get them out of shock, but this man was not in immediate shock, so that does not particularly apply to this case.

Q. Do you have in your medical library Campbell's "Operative Orthopedics"? A. Yes, sir.

Q. That is, your counsel has it?

A. Yes. It is written by a very well-known orthopedist.

(Testimony of Dr. Howard L. Cherry.)

Q. It states that the requirements of proper treatment begin with pre-operative care of the patient, and, regardless of the nature of the operation to be performed, the patient's general condition must be first thoroughly studied. I think we have already agreed about that? A. Yes, sir.

Q. Reading on Page 10:

"Treatment of shock * * * essentially that described above,"

and then it says:

"Time is an important factor. Surgery must be delayed until treatment of shock has become effective."

You would not disagree with that? [271]

A. I would not disagree with it, but this patient was not in shock, but if they are in moderate or even severe shock, they can be prepared for surgery usually within two or three hours. That does not mean days or 40 hours or anything else.

Q. You may be able to look at the hospital record and say that the hospital record does not disclose that he went into shock, but at that time and place would you have been prepared, had you been the doctor, to say that he wasn't going into shock?

A. I would say this, that with these injuries, with these potentials, he very well might have gone into shock, and that you should consider it, absolutely; but I also say that his blood pressure was 140 over 90 and when the blood pressure is 140 over 90 he is not in shock, and that there is nothing in there that indicates that he was in shock.

(Testimony of Dr. Howard L. Cherry.)

Q. You don't think the pulse being 112 is particularly indicative?

A. I don't think that pulse is.

Q. Reading from Page 374 of Campbell's "Operative Orthopedics," it says:

"In the accomplishment of this purpose in compound fractures the treatment of the wound and the prevention of pyogenic and clostridial infection assumes primary importance." [272]

A. Yes.

Q. "The object of emergency treatment is the conversion of a contaminated wound to a clean wound, thereby promoting early healing of the soft tissues, and the conversion of a potentially infected open fracture to a healed, closed one. Treatment of the fractured bone is secondary to the prevention of infection." A. Absolutely correct.

Q. Are you able to say Dr. Schneider did not consider that, when he cleansed the wound, put a dressing on it, a sterile dressing, and closed it?

A. I would say he gouged out the wound.

Q. Were you there?

A. No, but I read his testimony.

Q. A lot of people are strong for this so-called debridement——

A. I think any orthopedist should clean the wound or anyone who treats a fracture properly would clean the wound.

Q. That is what Dr. Schneider says he did. There may be some question in your mind as to whether he did it thoroughly or properly.

(Testimony of Dr. Howard L. Cherry.)

A. Cleaning a wound is not just a surface affair, but cleaning it down as far as it goes. You cannot adequately clean a wound in a conscious patient without an anesthetic. [273]

Q. You don't think the irrigating was adequate, then? A. Not just irrigating the surface.

Q. When you said his Seattle record showed most excellent treatment, did you read there where they got down and scrubbed inside the wound?

A. Yes, they did, as I recall it.

Q. I don't think they did.

A. May I read it? I don't know really. I don't remember that.

Q. We will give you a chance to look at it later.

Mr. John D. Ryan: Would he be permitted to read it since he has asked the question so he can give his answer?

Mr. Harr: We won't take the time now.

The Court: I have something to say about that. Stay on the main line.

Q. (By Mr. Harr): Continuing reading from Campbell's "Operative Orthopedics":

"The first consideration is the patient's general condition. Emergency measures are frequently necessary to combat pain, hemorrhage and shock."

Do we agree that he took any measures to prevent and combat pain? A. Surely.

Q. And to combat shock? [274]

A. He ordered blood; he didn't use it; didn't have enough shock to warrant using it.

(Testimony of Dr. Howard L. Cherry.)

Q. "Thereafter, attention is directed to the local condition. From the time of injury until the patient is ready for the local preparation, the wound should be protected by a dressing and the extremity splinted."

Is that what Dr. Schneider did?

A. Yes, and all this could be done in about fifteen minutes, and then he could go to surgery and get it fixed. The only element in my mind at all is the time element. That is the only thing and it is of extreme importance.

Q. You may be of the school that thinks there is only one way of treating a fracture. Won't you agree that there is more than one way of treating a fracture, a commonly accepted way of treating it?

A. Let me say this: There are a hundred ways of treating a fracture; but if it is a compound fracture, it should start with very adequate cleaning of the debris and closing the wound, if possible, and from there on in they can be treated in many ways.

Q. When you read texts about debridement, you also see that they excise the wound, don't they?

A. Sometimes.

Q. And cut away the tissue around it? [275]

A. Yes.

Q. Isn't the modern theory getting somewhat away from that excising——

A. The modern theory? I don't like the word "theory." The modern practice and the only modern practice I know of is to take away the dead tissue. You don't cut away much of live tissue.

(Testimony of Dr. Howard L. Cherry.)

You conserve all the live tissue you possibly can.

Q. Also reading from Compere:

"Two primary considerations must be kept in mind in planning the management of compound fractures. The first is prevention or treatment of shock, for the immediate preservation of life. Second is the prevention of infection in the wound."

Do you agree with that?

A. Yes, absolutely. It would be interesting to read that whole chapter.

Q. Then it sets forth the emergency care at site of accident: First, to give morphine and, second, to treat shock and clamp the blood vessels, the severed blood vessels.

A. What does it say about a fracture being an emergency, a compound fracture?

Mr. John D. Ryan: Right in the same paragraph you are reading there, Page 58. [276]

The Witness: That is a different edition.

Mr. Harr: Well, it says the primary consideration in a compound fracture——

Mr. John D. Ryan: Read it.

Mr. Harr: You can read it.

The Court: I can read it, too, after this is all over.

Q. (By Mr. Harr): Most authorities will agree that is the first consideration.

A. The very text you brought out and read to the Court says right down the line that you must treat the patient for shock, if shock is present; then you must clean the wound and clean it adequately.

(Testimony of Dr. Howard L. Cherry.)

Every one of these authorities have said that, and that is what I maintain as strongly as I can here.

Q. Campbell divides fractures into three types?

A. Yes.

Q. That is, compound fractures?

A. Yes, that is right.

Q. One with a laceration of an inch and a half, would you say that would come under Type 1?

A. I would say Type 2 in Campbell's classification.

Q. Would you say that was a wound of moderate or massive size?

A. What does it say? Read it, will you.

Q. Type 1: "Small puncture wounds caused by a protrusion [277] of bone from within out——"

A. Now, Type 2.

Q. And then it says: "——or by a bullet passing from without in, minimum damage to soft tissue."

Type 2: "Wounds extensive in length and breadth, but with little or no avascular, or devitalized soft tissues and relatively little foreign material."

A. Yes, I would classify this as Type 2. I don't believe there is much foreign material in this. I have seen nothing to indicate that there was. If there was, however, that is, if there was a lot of dead tissue, it would be Type 3. I believe this falls quite clearly into Type 2.

Q. Could it be your opinion might be wrong?

A. Yes, I have heard quite a little discussion about this.

(Testimony of Dr. Howard L. Cherry.)

Q. From Page 376:

"For small puncture wounds induced by indirect violence, the preliminary cleansing is usually sufficient. The serrated borders of the skin are excised, and the wound loosely closed. Probing in the wound, and injection of antiseptic solutions are contra-indicated, since these measures induce additional organisms into the wound and disseminate those already present."

Would you agree with that?

A. Yes, that is fine. That is Type 1, a very [278] small puncture wound from the inside.

Q. So, to go into the wound itself might be bad policy, if it is a small puncture wound. Would an inch-and-a-half wound be so construed?

A. No.

Q. If the doctor in attendance would so consider it, would you be in a position to say the way he treated this man's wound, by cleansing it and bandaging it and immobilizing it in the manner he did was wrong?

A. Yes, in my understanding of what this wound was like, I would consider it wrong; yes.

Q. All you know about what it was like is what you have read in the record? That is right, isn't it?

A. I had that source of information, by the record and by mouth. I didn't see the wound; that is correct.

Q. Is there not, Doctor, a respectable segment of medical opinion that would differ from what you

(Testimony of Dr. Howard L. Cherry.)

have testified to as to what should be done or what should have been done?

A. I don't really believe so. There is one thing that is different that I might bring out, and that is the treatment of war wounds. Often, war wounds where there are severe compound fractures are treated in the manner indicated. There are two reasons, the first being that they very frequently cannot be taken to a hospital, or usually cannot be taken to a hospital within the critical period; [279] and the second is they come in such great numbers that time cannot be spent by the limited number of doctors available. To the best of my knowledge, anybody who knows about compound fractures, in civilian practice, where you can get them to a hospital soon and have the facilities, would clean it carefully and close the wound promptly. The only exception I can think of in good, modern medicine is in the case of war injuries where it is impractical from a hospital point of view.

Q. You do know that there is respectable authority that would suggest the very treatment that was provided, to immobilize the wound after seeing that it was thoroughly cleansed and putting the patient to bed, and the general conditions observed?

A. I really honestly don't believe that any good medical practitioner, presented with all of the facts, knowing the condition of the wound and the type of fracture, and so forth, would honestly get up here and say that that was the correct way of treating this.

(Testimony of Dr. Howard L. Cherry.)

Q. Let's assume that practice was entirely wrong. If it is true, as our doctor testified, he got an ileus on the second day and that his condition became stabilized at the end of the second day, and that on the morning of the 12th of June, 40 hours after the accident occurred, approximately, he was transferred to Seattle. He was a little over four [280] hours on the way. Do you believe that four hours to be critical to his well-being, the time factor in itself, or the delay?

A. The time factor itself, after 40 hours—no, I don't think that time factor is an issue in my opinion in this case.

Q. In being transported in a modern ambulance —this particular one was a Cadillac, a 1952 Cadillac —and they had, so the attendant says, a pillow under his back to flex his back, and his leg elevated, and he was contained on the sides with a rail, and was transported in that manner—in your opinion, that four-hour delay should not have caused his condition to deteriorate or be a factor——

A. No.

Q. ——in whether or not his present condition was due to the early initial six- or eight-hour treatment you speak of?

A. I would like to answer those questions one at a time. I do think by far the most important thing is the six- to eight-hour period, which I referred to. I do not think the four hours' difference in treatment at the end of the 40 hours makes a bit of difference. I know that these Cadillac ambu-

(Testimony of Dr. Howard L. Cherry.)

lances ride beautifully, although they are not the same as sitting in bed with a nurse and attendants, but they ride beautifully; but if this man was injured and was [281] almost comatose when he got there and had suffered an ileus, there should be some awfully good reason, more than a few dollars, to warrant taking him 200 miles.

I am not making an issue of this. If that were the only thing involved, I don't think there would be much point in discussing this, but I don't think it is very good practice.

Q. You think it would have been injurious to him?

A. I think he probably was not as good after having taken that ride as if he had stayed in bed. I think it was very much to his benefit to go up there and get a doctor, yes, rather than just to lie here, but I do not make a strong point at all of the ride.

Q. He told you, did he not, that he passed out when he first reached the emergency surgery, that he was brought in, put on the table and the attending doctor inquired whether or not it would be all right to cut his trousers away, and then he passed out and he did not recall anything else until around four or five days later in Seattle. That was his testimony.

A. I didn't hear the testimony. I don't recall that. I recall him telling me he didn't go to surgery. That was from his own memory. Whether it was

(Testimony of Dr. Howard L. Cherry.)

reconstructed, however, I don't know, but I didn't hear from the testimony.

Q. Well, he was very heavily sedated on that trip; he [282] certainly did not suffer?

A. Oh, I think he got over it all right. I will answer your question this way: I don't think that is the critical point here. If the reason he was not given earlier treatment was so he could be sent there and the treatment postponed, I think then the ambulance system is wrong. If that system is substituted instead of adequate early care, I think it is wrong.

Q. You testified, as I understood you, that a fracture in the area of the lower third of the tibia is one of the worst places to have a fracture?

A. That is one of the worst places as far as circulation is concerned. I would much rather have one there than in my neck, for example, or my hip, but as far as circulation is concerned that is one of the poorer places to have a fracture, one that requires very careful care because of poor circulation.

Q. For that reason it is not at all uncommon, regardless of the treatment that is given, for them to develop osteomyelitis?

A. With the modern method, in good hands and with the giving of antibiotics, you seldom see it. You see it, yes, but not very often when they are in good hands and there is early treatment, in a clean wound like that.

Q. You thought he was well enough to return

(Testimony of Dr. Howard L. Cherry.)

to work, did [283] you not, in the first part of December?

A. He had assured me his job was not a hard one, and I thought it was not much different for him to be doing that kind of work than to be staying at home.

Q. That was within six months of the time the accident occurred?

A. Yes. Ordinarily, he would have been well.

Q. All that time you were his doctor and would treat him? A. Part of the time.

Q. Well, from the time he came from Seattle.

A. I was his doctor. I don't recall the dates; whatever dates have been used here, yes.

Mr. Harr: I think that is all.

The Court: Take five minutes more, Mr. Ryan, if you need it, on redirect. If you don't need it, don't take it.

Redirect Examination

By Mr. John D. Ryan:

Q. You have been handed Plaintiff's Exhibit No. 3, the U. S. Marine Hospital record. Would you look through that and find the pathological report that is contained in there?

A. You don't know how far down it is, do you?

Q. You have seen that pathological report, previously, have you? A. Yes. [284]

Q. What does it say?

A. Yes, I have seen it.

(Testimony of Dr. Howard L. Cherry.)

Q. Are you aware of what it says?

A. It says that the fragments of bone submitted showed no evidence of these fragments being involved.

Q. Were those taken out after the July 19, 1952, operation?

A. I don't recall. It would be one of the other operations. He had two up there.

Q. Would you state the medical significance of that finding?

A. The medical significance is that he did not have osteomyelitis in that particular piece of bone. I may further say that in my opinion he probably did not have osteomyelitis in that bone.

Q. To determine the infection, what further steps should have been taken?

A. A very logical step would be to get a culture. Sometimes you don't need it, but it would help you to find what the organism is.

Q. Have you seen Dr. Hunter's report, Defendant's Exhibit 24? A. I have.

Q. Would you give the significance of that?

A. It is the same thing. I don't know what these specimens were or when they were taken. In Dr. Hunter's report he says [285] he found the pieces of tissue that had been brought to him for examination had not caused osteomyelitis.

Q. You said the indicated treatment was cleansing, debriding and closing the wound?

A. And sedation, that being less important than the others.

(Testimony of Dr. Howard L. Cherry.)

Q. In this Type 1 treatment from Campbell's textbook that Counsel has read from, he indicated it should be loosely closed. What would "loosely closed" mean?

A. That means to close the wound, suture it and not drain it too much.

Q. Was that done in this case?

A. Not to my knowledge, not until going to Seattle.

Q. You have been handed, Doctor, X-rays from the Physicians and Surgeons and the X-rays from the U. S. Public Health Service, Exhibits 2-A and 2-B and Exhibit 3.

I will ask you to look at Exhibits 2-A and 2-B and compare them with Exhibit 3, which is one of the Physicians and Surgeons exhibits here, purporting to be an X-ray of the lower third of the left tibia, and compare it with the X-ray of the lower third of the left tibia taken upon arrival of the patient at the U. S. Marine Hospital in Seattle.

A. Very obviously it is the same leg and shows the same fracture, the main differences being that there is a little more displacement in the Seattle film than there was in the Portland film, and that there is a bandage around the leg [286] with a series of eight bandage clips. It is not too heavy a compression bandage, not as heavy as I would expect from the description given, but there has been some displacement of the fracture.

Q. What is the significance of the displacement?

(Testimony of Dr. Howard L. Cherry.)

A. In displacing it, it has a little more damage to the soft tissue.

Q. Would that be attributed to the nature of the bandage?

A. Well, the bandage was not enough to completely control the fragments. I don't know if that is terribly important at this particular time, but it was not enough to completely control it.

Q. What kind of specialist would you deem should be called as a consultant in a case of this kind in Portland, Oregon, at Physicians and Surgeons Hospital on June 10, 1952?

A. I cannot answer that question very accurately, speaking of the Physicians and Surgeons Hospital, because I am not well acquainted there. In Portland orthopedic surgeons do almost all acute compound fractures. It is my understanding it is not as much that way in Physicians and Surgeons as it is in the other hospitals.

Q. Do orthopedic surgeons practice at Physicians and Surgeons Hospital? A. Yes, they do.

Q. Is there a means or a way by which an orthopedic surgeon [287] is available in the City of Portland, during that time in 1952, I mean, for the treatment of such cases? A. Surely.

Q. Would you tell us what it is? Would you tell us how to go about it?

The Court: Never mind that. Are there any more questions, Mr. Harr?

Mr. Harr: I do not think I have any more questions. I was going to ask the indulgence of the

Court. I have one witness from Seattle that I would like to call at this time.

The Court: How long will it take?

Mr. Harr: Fifteen minutes, I believe. [288]

DR. GEORGE MAGID

produced as a witness on behalf of Defendant, and being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Harr:

Q. Your name is Dr. George Magid?

A. Yes.

Q. You are presently residing in Seattle?

A. Yes.

Q. Are you in private practice in Seattle?

A. At the present moment, yes.

Q. Would you state where you went to school and interned?

A. Chicago Medical School, graduating in 1951; interned in U. S. Marine Hospital in Seattle and, following that, I was assigned to Portland, Oregon, at the out-patient clinic downstairs here, the U. S. Public Health Service, where I was on duty at the time Mr. Morin came in.

Q. You have been handed Defendant's Exhibit No. 20——

The Court: Tell us what 20 is.

Mr. Harr: It is a photostatic copy of the hospital record, which I wish to substitute for the original.

Mr. John D. Ryan: No objection at all.

(Testimony of Dr. George Magid.)

Mr. Harr: I will ask you if in June, 1952, you were with the U. S. Public Health Service here in Portland, Oregon?

The Court: He said he was. [289]

A. Yes. No, not in June, 1952. I was still at the U. S. Public Health Service Hospital in Seattle as an intern.

Q. (By Mr. Harr): You came down to Portland—— A. In July, 1952.

Q. Would you look at that record, Exhibit No. 20, the out-patient record of U. S. Public Health Service, and tell the Court what you know about the treatment of Amos Morin?

A. I first saw him, Amos Morin, November 5, 1952, and he reported to me this entire story which I recorded to the best of my ability, and I will read it off.

Q. No. The history is substantially what you have heard here before. Eliminating the history, would you tell us what you observed and what your impression was?

A. When I saw him, he had a leg cast on the left leg which had been placed there by Dr. Cherry, I believe, according to the patient's story about, let's see, about a week before I saw him—it had been removed about two weeks before I saw him and the patient began walking, and then the patient told me that the pain was so severe that he went back to Dr. Cherry and the cast was reapplied the week before I saw him, and he came in to me, and had been walking with that cast around his leg.

(Testimony of Dr. George Magid.)

Q. Did you know he was under Dr. Cherry's care at that time? A. Yes.

Q. All right. Tell us what you next saw. Did you take [290] X-rays?

A. Then I called Dr. Cherry by phone and Dr. Cherry said, according to my notes here, that when he saw the patient first there was a little angulation at the fracture site, although the healing was almost complete; he reset it and put a new cast on, and said the healing was almost complete, and the patient was given a shorter cast below the knee with a walker on the cast; since then the leg became swollen and was slightly painful, and he was advised by Dr. Cherry to return to his office one week afterwards for X-rays.

Q. You saw him next when?

A. I believe that might be wrong—I believe I advised him to return to my office in a week for an X-ray. In the meantime I kept him off duty entirely, as far as the Public Health Service was concerned.

Q. In other words, he had returned to the Public Health Service and asked them to resume treating him, is that right? A. Yes.

Q. All right.

A. I gave him some APC, 10 grains every four hours, as needed for pain. He wanted some sleeping pills to help him sleep and I gave him some of those.

Q. What was the condition of the wound when you first saw him? [291]

A. The wound was healed. There was no open

(Testimony of Dr. George Magid.)

wound. There was a cast on it; the left knee was slightly swollen and was giving him some pain.

Q. At the time the cast was off when you saw him you say the wound was healed?

A. The cast wasn't off at first.

Q. Yes, but when the cast was off did you observe the wound?

A. Then he came back in a week and X-rays were taken at the time he came back, and they were reported on by the roentgenologist, and they showed the healing was not complete, although I believe the report shows that the callus formation was strong enough to support his weight.

Q. That is what the X-ray showed?

A. The X-ray report.

Q. That the healing was not quite complete. Go right on from one note to the other, if you will.

A. And then on the 17th of November he came back in and I removed the cast, and there were no openings in the skin that I can remember. I didn't record them, whether there were or not. However, I recorded the fact that there was solid healing. By that I mean that the X-ray report and my attempted movement of the fracture site showed the healing was pretty solid.

Q. Your notes say that on November 13, 1952, the X-rays [292] showed the healing as not complete. Then, one week later, or on the 17th of November, you note, "Solid healing." You don't make any note of any X-rays, so can you state from that

(Testimony of Dr. George Magid.)

note whether or not you are referring to the bone or the wound?

A. I believe I was referring to the wound first, and then from the fact that the X-ray report said healing—the callus formation was sufficient to support the use of the leg.

Q. Go on to your note of November 20th.

A. "Returns, walking with heavy limp; putting weight on leg; no pain except in ankle."

I measured the legs at the calf, and his left leg showed 37 inches and his right leg 37 inches. Swelling of the calf was not appreciable at all.

Q. Then you state, "Fracture site is strong and unmovable." A. Yes.

Q. What do you mean by that?

A. Just as I said.

Q. Then your notes show: "No pitting edema." What do you mean by that?

A. There was no edema. That is, when you would press in, the pitting would remain.

Q. And stay pinched, otherwise? A. Yes.

Q. Then the next time would be November 26. You have a [293] note: "Returns to pain over superior edge of plate just under skin. This only felt when puts weight on leg. Has noticed this since Saturday and has not put weight on leg since then. Skin thin. Discoloration over anterior part of tibia. Healing fracture. X-ray at radiologist."

That was your note on that day, was it not?

A. Yes, and I also advised him to walk less on the leg.

(Testimony of Dr. George Magid.)

Q. On December 1, 1952, there is a note: "Definite improvement in pain; now only light in area of plate and can put weight on it without pain. Walking around with cane." Was that your next entry? A. Yes.

Q. December 5, 1952: "Put on light diet. Will return in two weeks; feeling well; walking around." That is your entry on that date, is it? A. Yes.

Q. December 22, 1952: "Have patient certificate for full duty. He limps as yet; weakness of left ankle." Then it says: "Returns three weeks." Was that your entry on that date? A. Yes.

Q. In your last examination was his leg without a cast? A. Yes.

Q. Would you say as to whether or not the bone was solid and the wound was healed? [294]

A. Yes.

Q. They were? A. Yes.

Mr. Harr: You may examine.

Cross-Examination

By Mr. Thomas H. Ryan:

Q. Do you have any independent recollection of any of this?

A. Some of that, but not completely without trusting to the notes.

Mr. Thomas H. Ryan: That is all.

(Witness excused.)

(Thereupon Court was adjourned until Friday, July 23, 1954, at 10:00 o'clock a.m.) [295]

Friday, July 23, 1954—10:00 A.M.

(Mr. Luckey was thereupon excused by the Court from further attendance on this trial.)

Mr. Thomas H. Ryan: At this time, your Honor, I believe Counsel has agreed to stipulate that the hospital and doctor bills as represented in Plaintiff's Exhibit 26 are reasonable charges, and with that I believe we will close our case.

There is another item that will be helpful to the Court in deciding this case. I would like to call attention to Page 5 of the pre-trial order where we have listed the time loss. I have not totaled them, but the items come to the amount mentioned by Mr. Morin in his examination. Plaintiff rests.

(Plaintiff rests.)

Mr. Harr: With reference to the time lost, we might have to check to see if there is any portion of that that the Government had already allowed him by virtue of annual or sick leave, consistent with our position, as your Honor knows. [296]

Defendant's Testimony

BORIS OSHER

produced as a witness on behalf of Defendant and, being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Harr:

Q. Captain, you are now on duty with the U. S. Public Health Service in Portland, Oregon, are you not? A. Yes, sir.

Q. What is your capacity? What is the capacity in which you work with the Public Health?

A. I am a pharmacist's administrative assistant.

Q. How long have you been with the Public Health Service? A. Almost four years.

Q. You have been in Portland how long?

A. Almost two.

Q. Were you connected with the Portland office of the U. S. Public Health in November of 1952?

A. Yes, I was assigned here in September.

Q. When you were on duty downstairs with the U. S. Public Health Service, did you become acquainted with the plaintiff, Mr. Amos Morin?

A. I saw him there.

Q. You knew him, did you, by sight?

A. I knew him by sight and by name. [297]

Q. I will ask you whether or not you had occasion to be present on November 17, 1952, when Dr. Magid removed the cast?

A. Yes. Dr. Magid removed the cast, and directly next to the room in which he removed the cast is

(Testimony of Boris Osher.)

the diathermy room, and I was standing in the diathermy room when Dr. Magid sent Mr. Morin in for diathermy treatment.

I heard Dr. Magid describe to the patient how beautifully healed the leg was, and I also had occasion to notice it when Mr. Morin had his leg in the diathermy apparatus.

Q. How close were you to the wound at that time and to Mr. Morin?

A. I would say within six feet.

Q. Are you familiar with prescriptions that are issued at this station? A. I am.

Q. Have you had opportunity to review those prescriptions since this trial started?

A. I have.

Q. Did you examine the prescriptions that were given at each of the dates that the plaintiff came to the station, to wit, November 5, November 13, November 17, November 20, November 26, December 1, December 5, December 19, December 22, 1952?

A. Yes, I have all those. [298]

Q. Have you found in any of the prescriptions that there was any prescription for antibiotics of any kind?

A. No. There is no prescription for any antibiotic medication at all. The only prescriptions I found for this patient were prescriptions for aspirin, for APC and Nembutal.

Mr. Harr: You may inquire.

Mr. Thomas H. Ryan: No questions.

(Witness excused.) [299]

DR. JOHN E. LEONARD

produced as a witness on behalf of the Defendant and, being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Harr:

Q. Dr. Leonard, you are a duly licensed and practicing physician and surgeon in the City of Portland and State of Oregon? A. Yes.

Q. How long have you been a licensed physician? A. My license was granted in 1923.

Q. Would you state where you got your education, just briefly? A. University of Oregon.

Q. When was that?

A. I graduated in the class of 1923.

Q. Will you state where you got your internship and your initial training?

A. I interned at St. Vincent's Hospital in 1923 and 1924. In 1924-25 I was assistant to Dr. Pettit. In 1925 I went with Dr. Samuel Slocum and I was with him for a period of 12 or 13 years until his death.

Q. Any other doctors?

A. Well, in that time I was quite close to Dr. Charles R. McClure. [300]

The Court: Yes, I know him. I know about Dr. McClure.

The Witness: He helped me a good deal and advised me, and I helped him, and we worked together quite often.

The Court: Is he living, do you know?

(Testimony of Dr. John E. Leonard.)

The Witness: Yes, he is.

The Court: Retired, though?

The Witness: Yes, but he does some examinations, but he is retired.

Q. (By Mr. Harr): I first became acquainted with you in 1928 when I was adjusting some insurance. At that time I believe you were over with Dr. Slocum, is that right? A. Yes.

Q. Was that in the Mohawk Building in Portland? A. Yes.

Q. Dr. Slocum was the head man in charge of the National Hospital Association?

A. He did surgery for them, and Dr. Sabin did surgery for them.

Q. You worked under Drs. Slocum and Sabin?

A. I was Dr. Slocum's assistant.

Q. During all of that time, from that time to the present, have you devoted your time and experience to general surgery? A. That is right.

Q. There is a controversy here or, I should say, there was a controversy here involving the Medical Society. During that [301] time were you a member of the Society?

A. No, I was not. We had no personal enmity, but I felt I wanted to run my own business the way I wanted to.

The Court: I know all about that. That was all brought out in the Medical case.

Mr. Harr: Yes, I appreciate that.

Q. Subsequently, however, you became a member of the Society?

(Testimony of Dr. John E. Leonard.)

A. Yes, and I am a member now.

Q. Are you acquainted with Mr. Amos Morin, the plaintiff in this case?

A. My recollections are very vague. He says I saw him, and I most assuredly did, but as to looking at his face now, I would not be able to say he was the man.

Q. The records of the Physicians and Surgeons Hospital show that you were somewhat in charge of his case during his stay at the Physicians and Surgeons Hospital from 1:15 of June 10, 1952, and 8:00 o'clock the morning of June 12th. You are familiar with those records, are you not?

A. I remember seeing on the record that I saw the man, and I will say that I certainly did see him or it would not have been there.

Q. The Physicians and Surgeons Hospital at that time had, as residents, Residents Drs. Schneider and Stalder? A. Yes. [302]

Q. Had you been working with those doctors somewhat closely for some period of time?

A. Yes; during those boys' residency at the hospital I was very close to them. I had known them prior to that. As a matter of fact, they served at Physicians and Surgeons and then Dr. Stalder went to New York for his internship and Dr. Schneider went to Ancker.

Q. Did you happen to know from other sources of the type of hospital Ancker Hospital is, whether it is a good hospital or whether or not they have a lot of surgery there?

(Testimony of Dr. John E. Leonard.)

A. I think it is one of the best hospitals for surgery, emergency work, that there is in the country. I have not seen them all, but why I am particularly impressed and know is that my son-in-law just finished his internship there this year, and I was back there with them during the holidays. All of the accidents and all the emergencies that happen in St. Paul go through Ancker Hospital, and they have terrific service.

Q. With that background, did you have every reason to have full confidence in his judgment and in the way he treated patients? A. Yes.

Q. May I ask you if you relied somewhat on the judgment and treatment that he accorded?

A. Yes.

Q. And the attention he gave? [303]

A. Yes.

Q. The record shows, or the testimony has been, rather, that you were notified early in the afternoon of June 10th of the admittance of Mr. Morin to the Physicians and Surgeons Hospital.

The testimony further shows that you were advised of what was done, that the wound was cleansed and that there was a bandage applied, a compression bandage, and the leg immobilized, splinted, X-rayed, and that he was taken to his room.

You at this time, as I understand it, have no personal recollection of that situation?

A. That is right.

Q. But, assuming that to have been the fact, that

(Testimony of Dr. John E. Leonard.)

you were thus notified and that his injuries were of the severity that you now know—a compound fracture of the lower third of the left tibia and a fracture of the back—were you in accord and are you in accord with the treatment that was given at that time?

A. Naturally my memory has been refreshed by Dr. Schneider talking to me and telling me he called me, and if he had not called me he would not have said so.

Q. Go ahead.

A. It is my own personal opinion that the treatment of this man at that time was very adequate and excellent. [304]

I would like to go just a step further and say that if I ever have a compound fracture and a broken back at the same time, I would not want any different treatment than was accorded in this case to this man.

Of course, I understand fractures sometimes are treated in different ways.

Q. Yes, fractures sometimes are treated in different ways, and there is a respectable segment of the medical profession who feel the wound must be closed within six to eight hours. Do you subscribe entirely to those views?

A. No, I don't. I think every case in an individual case and you must observe it and treat it accordingly. You must prepare yourself for certain things that might happen.

I think anybody who has had an injury like this

(Testimony of Dr. John E. Leonard.)

man sustained has had about all he should have in one day. I never have believed in this immediate setting of fractures.

However, that is my own personal opinion and I have seen lots of fractures, and it is my own personal opinion that would certainly add to his shock.

A man might be holding his own and be in pretty good shape, in better shape than you would really believe, but I have always felt—and again this is my own opinion over several years—that he is standing up pretty well under the present load and if you add a little more burden to it you could push him into shock, shock of different [305] degrees.

Also, I certainly do not subscribe to the reasoning that a fracture should be set immediately. I do not think that is necessary. That again is my own personal opinion.

Q. Do you believe that a respectable segment of the medical profession would look at it and does look at it the same way you do?

A. I think there will be men that will go along with my reasoning, yes. I think that is up to the individual.

Q. Who is the best judge, normally, of whether or not a person should be rushed to surgery, given a general anesthetic and the reduction made? Who normally is the man to make that choice?

A. The man on the job.

Q. I think the record in this case will bear out

(Testimony of Dr. John E. Leonard.)
the fact that this man probably was a hypersensitive person, which is nothing to his discredit.

Mr. John D. Ryan: I object to that, your Honor. There has been no testimony of that sort in the record at all.

Q. (By Mr. Harr): Are there hypersensitive people?

A. Certainly; people's tolerance to pain varies.

Q. Take two individuals with the same type of injury; one might tolerate it with no pain and another man might be affected seriously, is that [306] correct?

A. Yes; given two similar patients, one might have more complaints than the other; that is, complaints of more pain, if that is what you mean.

Q. If a person comes to a hospital, as Mr. Morin did, complaining severely of the pain in his back and in his leg, is that a circumstance that a doctor will take into consideration in determining what should be done with him?

A. Yes. He should make him comfortable and something should be given to allay his pain and make him comfortable, generally an opiate or some derivative.

Q. I think you have already stated you approve of the things Dr. Schneider had done?

A. Yes.

Q. Do you feel that the compression bandage and splint, after cleansing the wound, properly immobilized the leg?

A. Yes. I approve of it. I approve.

(Testimony of Dr. John E. Leonard.)

Q. That would have been your way of doing it, had you been there?

A. I would not have done it any differently.

Q. Having made the rounds of the hospital the morning of the 11th, was there any necessity, then, of changing the treatment that you found; the things that were done met with your approval?

A. No, sir; no necessity for changing the treatment that I found. [307]

Q. On the afternoon of the 11th I believe you talked, did you not, to Dr. Morrison and possibly to Dr. Craig about whether or not it would be safe and a satisfactory proceeding to transport Mr. Morin to the hospital in Seattle?

A. Dr. Morrison called me—my remembrance of the case—after I had examined him, and asked if I felt he could make the trip to Seattle and I said I felt in my opinion that he could be moved to Seattle.

Q. That was after the six- to eight-hour period that we have spoken of here?

A. Yes. That was the next day.

Q. With the type of bandage and splint, did you feel the leg was immobilized sufficiently for him to make the trip? A. I did.

Q. Dr. Cherry yesterday testified that after Mr. Morin left the Seattle hospital he came back to Portland and that there was infection of the wound and they had made an incision up there. You were familiar with the record to that extent? They had made an incision and put in a sliding bone graft.

(Testimony of Dr. John E. Leonard.)

A. That was done in Seattle?

Q. That was done in Seattle. A. Yes.

Q. He returned to Portland about the middle of August and then in the latter part of August, August 26th, I believe, [308] Dr. Cherry, having stated there was infection in the wound, manipulated the wound to reduce a slight bowing. Would you have done that had that man come to you?

A. I would not.

Q. Why?

A. Not with the presence of an infection.

Q. Why?

A. As I understand it, to angulate a wound more than five degrees and manipulate it and rebreak a wound certainly does more trauma to it than the presence of an infection. I would not have done it. I have no quarrel with anybody but as for myself I would not have done it.

Q. Would that have a tendency to inflame and reactivate the infection, if there were an infection?

A. I would say yes.

Q. In January, January 22nd——

A. I am going on the assumption that there was an infection at the time.

Q. Yes. It has been testified by Dr. Cherry that there was osteomyelitis present in this wound in January, 1953, and that the man was complaining of pain from the Egger's plate; that he took him to the Providence Hospital and removed the plate and sutured the wound. He said the infection extended down to the bone and in the bone. Would

(Testimony of Dr. John E. Leonard.)

you have sutured the wound under those circumstances? [309]

A. We all do things differently.

Q. I am asking your opinion.

A. Personally, I would not. I would leave it open and pack it with vaseline.

Q. Why?

A. Well, it allows drainage and it allows healing from the bottom up. You are not making a full cavity out of it. I prefer to leave these wounds open.

Mr. Harr: You may inquire.

Cross-Examination

By Mr. Thomas H. Ryan:

Q. Considering a bone fracture of the lower third of the tibia——

Mr. Harr: I think I have one more question.

Mr. Thomas H. Ryan: Go ahead.

Direct Examination
(Continued)

By Mr. Harr:

Q. You are familiar with Campbell's "Operative Orthopedics," are you not? A. Yes.

Q. They, in that work, break these fractures down, compound fractures, into three groups. The first group consists of small puncture wounds, caused by a protrusion of bone from within out. That is Type 1. Type 2 refers to wounds extensive

(Testimony of Dr. John E. Leonard.)

in length and breadth. Would you consider this Type 1 or Type [310] 2? A. 1.

Mr. Harr: That is all.

The Court: Ask him to explain or state briefly what osteomyelitis is.

The Witness: A osteomyelitis is a bacterial infection that gains entrance into the bone either by direct infection or by hematogenous means.

Q. What do you mean by hematogenous?

A. Hematogenous, by the bloodstream.

Q. How would it come into the bloodstream?

A. It would have to get in in the site of infection where the abscess is, or infected material.

Also, it has been said osteomyelitis is developed where there have been septic tonsils. I have never seen that happen, but not too long ago I read of it. I would say osteomyelitis by the bloostream is a possibility, but I don't think it happens too often.

The Court: In the old days we called it tuberculosis of the bone.

The Witness: Yes, sir. However, it has been found they are two separate things. They called it osteomyelitis, but it was tuberculosis, and vice versa.

The Court: It results in a sloughing of the bone?

The Witness: Yes. [311]

The Court: So that frequent operations sometimes are necessary?

The Witness: That is right, sir.

The Court: Necessary to keep ahead of it?

The Witness: Yes.

(Testimony of Dr. John E. Leonard.)

The Court: And sometimes a difficult question arises as to whether to amputate the whole limb.

The Witness: That is right. Of course, with the new antibiotics, which are not a cure of themselves but which certainly have been of wonderful help, we don't see those cases like we used to.

The Court: I tried a case about two or three years ago in Arizona where they hacked at a leg fifteen times and never caught up with it.

Q. (By Mr. Harr): Would infected tonsils be possibly a cause that would bring about this condition? A. Up here (indicating)?

Q. Yes.

A. They would come in the same category as tonsils would, yes, but those causes are rather remote. They are possibilities to us which I could not evaluate with any degree of accuracy. It is said, however, that those things do happen.

Q. Following the time Mr. Morin left Portland on June 12th, he went to Seattle and then there was a closed reduction or, rather, a reduction by manipulation and the wound closed, and [312] the record here shows that the wound was completely healed and that on July 11th, a little over a month from the time the accident happened, union not having taken place, there was another operation; there was an operation, an open reduction and a bone graft made and an Egger's plate applied. Is there danger in open operations?

A. Yes, there is. Any time you cut the skin anywhere there is danger. Even under the most ac-

(Testimony of Dr. John E. Leonard.)

cepted technique you are running a chance of having infection, whether operating on a bone or having an appendix out. There is always danger in a lesion, either traumatically or with a knife; under the most sterile conditions it can be infected.

To get back to this osteomyelitis in this case, the time element is certainly a factor to be considered. I certainly think we would have to stretch our imaginations pretty much to the breaking point to assume that what happened here in Portland was the cause of this osteomyelitis. Certainly the man in the Marine Hospital in Seattle would not have done an open operation, with a sliding bone graft, if there had been any infection at that time, any infection there. It just does not seem reasonable or plausible. It just does not seem at all plausible or practical. It does not even seem reasonable that all this would happen in an infected wound.

Q. All right. You find here that the wound had healed, [313] an open operation performed, a specimen taken, and the specimen microscopically examined, showing no infection.

Is that a further indication that there was no infection there? A. Yes.

Q. Then we find the man left the Marine Hospital against the advice of the doctors in attendance, and the record again shows no gross infection.

What is meant when we say "gross infection"?

A. Where it is very evident; you could look at the part infected and see.

Q. That is, visually?

(Testimony of Dr. John E. Leonard.)

A. Yes. You could see it.

Q. And you could not see it?

A. There is one thing I would like to make very clear, and that is I happened to hear some of Dr. Cherry's testimony yesterday, and I have no quarrel with him, and if that is the way he wants to do it, that is fine, but just because someone else chooses to do it a little differently does not make him incomparable.

I would like to illustrate that by something that pertains to the legal profession. My father was a lawyer and I know as a young man he took me down to John Cassidy's office. They were trying a case together, and the arguments they put up were terrific. I never heard how it turned out, [314] but, anyhow, it shows how you can have different opinions, and I think that a difference of opinion is healthy and is proper. I certainly welcome it.

Q. I want to ask you this question now: With reference to an operation in the lower third of the tibia, regardless of the care and attention given, infection can come into the wound, is that not correct? A. That is right.

Q. I am bringing this out for the reason that I think Dr. Cherry rather glibly says the records at Physicians and Surgeons Hospital in Portland are inadequate, and, therefore, the treatment was wrong, and he glosses over all of these circumstances that happened from that time on down and he says that because he had osteomyelitis the fault of it was

(Testimony of Dr. John E. Leonard.)

traceable to the first 40 hours of treatment in Portland, because they did not close the wound.

There was an operation in Seattle; that is one source of the osteomyelitis.

A. It could be one source, yes.

Q. Let me ask you this: He fell from a stretcher, out on the lawn, just before he left the Seattle hospital. The record shows that he denied it. They asked him about it, but he denied it, but his wife testified that he fell on the lawn—I think that is what she said. Could that have injured him sufficiently to have aroused the situation? [315]

A. There is a possibility, but not having examined the man—sometimes the amount of trauma is not necessarily indicative of the results. For instance, an old lady slips on a rug and breaks her hip and, while that is sometimes a mild trauma she may develop serious complications from it. On the other hand, there are times when people will have a very damaging injury and get out with little or no trouble.

Q. Then, further, if there were infection in the wound, as Dr. Cherry said, and he manipulated it and rebroke it to a certain extent to straighten out a slight angulation, is that a circumstance that could have been the cause of the osteomyelitis later on?

A. You are opening up a new avenue for the entrance of the infection. I am assuming that was the condition and certainly opening up new avenues for infection.

Mr. Thomas H. Ryan: It should be understood

(Testimony of Dr. John E. Leonard.)

that this was not an open reduction; it was a closed reduction.

Mr. Harr: That is true. It was a closed reduction. "Manipulation" is what I said, I believe.

Q. Is that an avenue of further trauma to the bone that could be the cause of osteomyelitis, a possible cause; put it that way?

A. You mean the manipulation of a closed reduction?

Q. Where there is infection.

A. Where there is infection in the wound at that time? [316]

Q. Yes. A. That is a possibility, yes.

Q. Could the osteomyelitis have come from the operation that Dr. Cherry performed at the time of taking out the plate?

A. Well, we can get infection any time that we open any wound or go back into it. There is always that danger. When we put screws into the bone, into the cortex, and do these other things, even in clean cases, so to speak, they are all possibilities.

Q. In connection with the operation performed by Dr. Cherry in removing the plate, attention was called to the fact that they sent a specimen and the pathologist came back with a report to the effect that there were fragments of bone, screws and a metal plate; there is no mention of any infection. Is that significant?

A. That is significant in the fact that what they sent to the laboratory was not infected, but that is all, just the tissue that they sent. They just ex-

(Testimony of Dr. John E. Leonard.)

amined what was sent to them, and the report states that as far as the examination shows, it shows no infection.

Q. Must we not assume that there was a microscopic examination of those segments?

A. I suppose there was, but even then——

Q. What reason would there be to send these specimens to [317] the pathologist?

A. Because in every hospital you are obliged to send specimens to the pathologist.

Q. We would not expect Dr. Cherry to send a specimen down with two screws and a metal plate just to have the pathologist tell him that that is what this specimen consisted of, just a metal plate and screws?

A. You would send them to your staff pathologist for identity. That is what he did there.

Q. For examination? A. That is right.

Mr. Harr: I think that is all.

Cross-Examination

By Mr. Thomas H. Ryan:

Q. Doctor, do you consider a compound fracture of this particular type a serious injury?

A. Yes.

Q. Do you consider it creates an emergency?

A. Well, it all depends on what you call an emergency and what you call a type of emergency treatment.

As I just got through saying, I think a fracture of that type—with a fracture of that type, although

(Testimony of Dr. John E. Leonard.)

the man seemed to be standing up quite well, he has had a lot of trouble, and my feeling is that it depends on the type of [318] wound and the length of the wound as to what you should do. I would think the first aid and cleansing the wound and applying the sterile dressing, the compression bandage and the immobilization would be what I would call emergency treatment.

Just as I said a while ago, there are some who feel that they should go right ahead and reduce it. I have no quarrel with those people, but you have to take your case as a whole and evaluate it and look ahead and anticipate what you may expect. You may be wrong in your anticipation, however.

Q. Isn't there other treatment, besides a superficial cleaning of the wound, short of reduction, that should be given?

A. What do you mean by that?

Q. Debriding the wound.

A. Debridement?

Q. And irrigating it internally.

A. You can get into a field of controversy there. There are different phases of this so-called debridement and different stages of it.

In a puncture wound I believe in irrigating it with saline. You can always cut the tissue out. Some people believe in a radical debridement where they take away the normal tissue. Others do a moderate debridement, oh, even [319] four or five or six days later. If necessary, you can go in and do a secondary. A puncture would, I think, should be irrigated

(Testimony of Dr. John E. Leonard.)

with a normal saline solution with a compression dressing and then splinted; a light irrigation inside and then it should be washed thoroughly on the outside.

Q. Don't you think it should be closed?

A. I do not. A wound an inch and a half or an inch long will heal by itself. I personally see no necessity of closing it, and the only thing closing will do is to make a finer scar. Besides, in closing it you are making it a closed cavity. You leave it open and the serous drainage and any blood that may come later will drain.

We know that these types of fractures swell and become edematous. I think it is a matter of opinion. I think a man is perfectly justified in his own mind in a case of this type not to close it.

Q. You are familiar with the "Pictorial Handbook of Fracture Treatment," are you?

A. No, I am not. I don't know anything about it.

Q. Do you want to take a look at it?

The Court: There is no point to that. He has not seen the book and he cannot take the time to read it now.

Q. (By Mr. Thomas H. Ryan): Do you agree with this statement:

"A compound fracture constitutes one of the most serious of all emergencies. The involved [320] bone is exposed through the skin and must be considered to be potentially infected. The need for prompt and adequate surgical care is as urgent as that for the treatment of acute appendicitis, a ruptured spleen

(Testimony of Dr. John E. Leonard.)

or perforation of a peptic ulcer. Delay in treatment of a compound fracture may result in infection, with osteomyelitis, septicemia, non-union, prolonged invalidism, loss of a limb or death."

Do you agree with that statement?

A. I do not. I think that is up to your own individual opinion. You have to judge each case by itself. Just simply because a man does not go in and cut away a lot of normal tissue, and do this debridement—I think that is a matter of judgment that a fellow should decide for himself. After all, a man's life is what he is figuring on, and I cannot agree with that entirely, because that takes in an over-all picture of compound fractures. I think all of these things have to be rationalized on an individual basis.

Q. You do not remember this case at all?

A. I only remember it by—I remember talking to Dr. Morrison and the chart shows that I saw him, and I certainly did. I looked over the chart.

Q. I am not saying you did not see him.

A. Well—— [321]

Q. You do not remember of your own memory now what happened?

A. No, I don't, only what has been told me.

Q. You were afraid to go in and do surgery, that is what you think now, because of his condition?

A. You say I was afraid?

Q. Yes. A. I am not afraid of anything.

Q. I am not saying from the standpoint of personal fear. You say that you felt that his condition

(Testimony of Dr. John E. Leonard.)

was such that he could not stand surgery at this time?

A. What I said is in a case like this, a man comes in and I think the record and everything shows his blood pressure was holding up pretty well; there was no severe shock—but I have seen them go into shock within a quarter of an hour. I thought anybody who has had a compression fracture of the lumbar vertebra, knowing what would follow that, and has a compound fracture of the leg, I felt he needs conservative treatment and there is no hurry, as far as I am personally concerned, in going in and setting the leg and giving an anesthetic. You have to manipulate it; possibly you may have to plate it, and you could precipitate shock. That is a possibility and it could happen. I could see no reason for hurrying it.

I again state I am not an expondent of [322] immediate reduction of fractures in all cases. I have no quarrel with those who maintain that should be done, but I think each case should be based upon its own circumstances. It is my own feeling that at that time he had had enough for the time being, and that is the way I feel about it now.

Q. But you did not think he had had too much to stand a 200-mile trip to Seattle?

A. That was two days later.

Q. You feel a Yucca board splint is the proper type of splint to apply?

A. As far as I am concerned, yes.

(Testimony of Dr. John E. Leonard.)

Q. Do you agree with this statement from the same book:

"With rare exceptions, Yucca board or single splints (aluminum, wire, basket) of any kind should be used only in first aid or emergency procedures. This applies in war as well as in civilian practice. Yucca board splints are most unsatisfactory in the treatment of fractures of the long bones."

A. That is his notion. I have used them a long time and have found, as far as I am concerned, they immobilize satisfactorily. If a doctor wants to use a stiff board or plaster or something else, that is all right, but I have used it.

Q. Do you agree with this:

"They do not fit the contour of the limb [323] accurately and can be applied only to one side of the limb. Motion between the fracture fragments, with displacement, occurs all too often."

A. As far as I am concerned, in my own experience they have been satisfactory and, even in plaster, you can get motion between your fragments.

Mr. Thomas H. Ryan: I think that is all.

Mr. Harr: I think that is all.

(Witness excused.) [324]

BETTY ANN FREEMAN

produced as a witness on behalf of the Defendant and, being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Harr:

Q. Is it Miss Freeman or Mrs. Freeman?

A. Mrs. Freeman.

Q. Mrs. Freeman, you are a registered nurse?

A. Yes.

Q. Where did you take training?

A. Providence Hospital School of Nursing.

Q. When was that?

A. In 1947 I graduated.

Q. In 1952 were you regularly employed as a nurse in the Physicians and Surgeons Hospital?

A. At the time of this case I was doing vacation relief. I was employed for two weeks. I had previously worked in the emergency surgery two years.

Q. I beg your pardon?

A. I had previously worked in the emergency surgery for two years.

Q. Was that at Providence?

A. No, at Physicians and Surgeons; and I did vacation relief for the regular girls.

Q. On this occasion you were doing some relief at that [325] time? A. Yes.

Q. Would you look at Plaintiff's Exhibit No. 1, the last two pages, I believe? That is the record that you made showing Mr. Morin admitted to Room 115.

(Testimony of Betty Ann Freeman.)

After looking at the last page, the out-patient's record, that was made by you, was it not?

A. Yes, sir. That would indicate, "Morphine, 1/6 gr. for pain at 1:30; compression dressing to left lower leg; Abbocillin, 800,000 units; catheterized; specimen to laboratory, and X-rays."

Q. That was your record? A. Yes.

Q. Dr. Schneider, when he was on the stand, testified that he was right there and he rendered this emergency treatment, and he likewise testified that he irrigated the wound after having first administered a mild antiseptic and detergent to the bruised area and the abraded area of the wound; then he irrigated the wound and put on a compression dressing.

Mr. Thomas H. Ryan: There is no testimony he irrigated the wound. He said he gave it a superficial cleaning.

Mr. Harr: That is not my recollection.

The Court: Go ahead.

Q. (By Mr. Harr): That treatment does not appear in your notes as to what was done. Let me ask you this: In the light [326] of that testimony—were you in attendance there at all times?

A. No, sir.

Q. Why weren't you in attendance?

A. I was in and out of the emergency surgery. I had to get the morphine and I went to the pharmacist's for the penicillin. I had to go to the cupboard out in the hall for the splints and I took the

(Testimony of Betty Ann Freeman.)

specimen to the basement to the lab. I had to go to the office for the morphine.

Q. You said you had to go to the office for the morphine. Did they keep all the narcotics locked up?

A. Yes.

Q. Who has the key?

A. The nurses' supervisor.

Q. Do you have a personal recollection as to whether or not she was in the office when you went there? A. No, I don't remember.

Q. If the supervisor is not in the office, you must run her down and find her?

A. Yes, that is right.

Q. She carries the key with her? A. Yes.

Q. What about the penicillin, where is that kept?

A. That is in the pharmacy.

Q. You go to the pharmacy and it is given to you at that [327] particular time? A. Yes.

Q. And it is issued to you? A. Yes.

Q. Is it issued on your order or your request?

A. Yes.

Q. You mentioned a splint that you had to get.

A. Yes, had to get a splint.

Q. Do you have a personal recollection in this particular case of a splint being applied?

A. Not of it being applied, no. I remember going out—as I remember, I got two short wooden splints and gave them to Dr. Schneider.

Q. By "short," do you mean two or three feet in length? A. (Indicating.)

Q. You took them to Dr. Schneider?

(Testimony of Betty Ann Freeman.)

A. Yes, sir; I did.

Q. Do you have any personal recollection of the type of bandage that was used, the dressing and bandage?

A. From reading my nurse's notes, yes.

Q. I will ask you if it is true that your nurse's notes show there were three packages of compression cotton? A. Yes.

Q. And there were four three-inch and one six-inch bandages? A. Yes. [328]

Q. Do you have any recollection, any personal recollection, of the size of the leg after it had been immobilized with the splint and bandages?

A. I believe so.

Q. Would you demonstrate to the Court what you recall? A. (Indicating.)

Mr. Harr: You may inquire.

Mr. John D. Ryan: No questions.

(Witness excused.)

(Recess.) [329]

DR. WILLIAM R. KING

produced as a witness on behalf of the Defendant and, being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Harr:

Q. What is your full name?

A. William R. King.

Q. Where are you located, Dr. King?

A. At Seattle, Public Health Service Hospital.

(Testimony of Dr. William R. King.)

Q. We refer to it as the Marine Hospital, is that right? A. Yes.

Q. Where did you go to school?

A. I graduated from Tufts Medical College, 1948.

Q. From there tell us where you did your internship?

A. I interned at the Marine Hospital in Boston, Massachusetts, and then had active duty in the Coast Guard for six months, and then out-patient duty; then I was in Norfolk, Virginia, at the Marine Hospital there, and then was transferred to Seattle and started my surgical residency there in July, 1951.

Q. In 1952 were you a resident there?

A. Yes. I was the second resident. I was assigned to the orthopedic service.

Q. That is what you are preparing yourself for, surgery, generally, is that correct?

A. Yes. [330]

Q. Do you have a personal recollection of Mr. Amos Morin when he came to the hospital in Seattle?

A. Not when he came, but I did have him as a patient after the 1st of July.

Q. You have been handed Plaintiff's Exhibit No. 3. There has been a little confusion, I believe, in the evidence that has been presented thus far about the size of the wound. The testimony—of course, you heard it; you were here in the courtroom—was that there were lacerations, two of them, one about an

(Testimony of Dr. William R. King.)

inch and a half long and one about an inch. There is some evidence in this record that at the Seattle hospital one was of larger proportions.

Would you kindly refer to the record now and explain that?

A. In the physical examination given on admission it was stated there was a laceration approximately 12 cm. long and 4 cm. wide.

Q. In inches, how big would that be?

A. That would be five and a half inches long and a little less than two inches wide.

Q. I think the evidence shows also that there was blood incrusted over the area?

A. That is right. On Dr. Wagner's operative notes he said he removed the blood-encrusted dressings and splint and then the wound was one and a half inches long and another one inch [331] long.

Q. Is that the heading on Page 11 of the report where it says, "What Was Done," which reads:

"The region of the lacerations, one about one and one-half inches long and the other an inch long, was thoroughly scrubbed with soap and water, followed by a tincture of zepharin preparation."

A. That is correct. Where I took the size as being 12 cm. was taken from the physical examination as written by the intern. I think it should be noted that at the beginning of the physical examination the intern stated that, "The patient has a full body cast and leg cast." Therefore, at the time he wrote it he was not able to see the wound and describe it, so this description was not put there or

(Testimony of Dr. William R. King.)

observed at the time of surgery because he was not listed as being present at the time of closing the wound; apparently from what someone else had told him.

Q. Doctor, refer to Page 18-A of the record that you have before you. There is an entry there, dated July 5, 1952. Do you find that? A. Yes.

Q. Who made that entry? A. I did.

Q. What was that entry made from, your personal examination? [332] A. Yes.

Q. What does the entry state?

A. "Check wound; well healed; sutures removed; cast is loose and movement in fracture site; will have to recast."

Q. What did you mean when you said the wound was well healed?

A. The wound which was closed by Dr. Wagner had healed all right and the sutures could be removed.

Q. July 5th—Dr. Wagner made the original treatment and sutured the wound, is that what the record shows? A. That is correct.

Q. But there had been no open operation done as of that date? A. No.

Q. So the lacerations of one and a half inches and one inch are what you are referring to there?

A. Yes.

Q. They were well healed?

A. Yes, correct.

Q. Is there any indication from your notes or

(Testimony of Dr. William R. King.)

from the record anywhere that there was any infection at that time?

A. None at that time.

Q. How about the hospital chart as to fever or swelling or redness or tenderness? What does it show about that? [333]

A. At that time, if there was redness or swelling, I would have written it down. At that time I felt the wound was completely healed.

I can refer to the temperature curves. On Pages 27 and 28, running from June 26th through July 9th, his temperature was completely normal.

Q. Any significance about that?

A. Well, as far as we were concerned, it shows no evidence of infection.

Q. If there were infection, there would be a fever rise? A. There usually will be, yes.

Q. Had the wound become contaminated in Portland, Oregon, on June 10th, would you normally have expected some active infection by July 5th? A. I feel definitely that we would.

Q. Would you look on Page 19? I think there is a note there by Dr. Keever, July 24th. Who is Dr. Keever?

A. Dr. Keever started his internship on July 1st of last year.

Q. It says:

"Sutures removed this a.m. Wound appears to be infected and skin edges are not healing in the center of the wound."

Is there any other evidence in the record, other

(Testimony of Dr. William R. King.)

than that, to indicate that there was infection? [334]

A. I have not noted any; in my discharge summary I stated that there was no evidence of gross infection at the time of discharge. The patient did have swelling following his open reduction and a separation of the wound edges and there was serous drainage, but there was no evidence of gross infection.

Q. Drainage, a layman's view means infection. Is that necessarily true?

A. No; an open wound will drain.

Q. What about sloughing? Could that also be said of sloughing?

A. Sloughing is dying tissue.

Q. That means there is actually a bacterial infection?

A. There is a certain amount of superficial infection in any open wound. There was no drainage of pus indicating a gross infection.

Q. When you say "gross infection," that means visually, what you can see? A. Yes.

Q. Your statement in your summary was that there was no gross infection, is that correct?

A. That is correct.

Q. You became fairly well acquainted with Mr. Morin during his stay there? A. Yes. [335]

Q. Would you tell us a little about him? I mean, what kind of a patient was he? Distinguish him from different types of patients, if you can, and state it briefly.

A. I think, as evidenced by the record, he was

(Testimony of Dr. William R. King.)

a difficult patient to control, what we consider to be a low-threshold-pain type and, therefore, needed considerable medication, and he had to have the cast cut following his operative procedure because he could not tolerate the pain that he had.

Q. Please run through the nurse's notes rapidly and tell us generally what those complaints were as to pain.

A. "Patient restless; complaining of severe pain in leg" at one point.

Q. Cover it by dates, if you can.

A. He was admitted on the 12th, at which time he was difficult to arouse. He returned from surgery at 8:30—9:30, "Patient very restless at intervals; was given sedatives for extreme restlessness; was twisting and turning in bed; calling aloud and took only sips of water."

On the 13th he was moaning at frequent intervals and had a poor day; patient very confused, turning from side to side.

On the 14th he was given Demerol for pain. "Awake; moaning; twisting and changing positions constantly when awake. Complains of pain in back and side."

Demerol was given at 5:15 and the notes say: "Poor [336] night."

Q. At 3:10 in the morning do the notes show he had pain, that there was extreme restlessness and he was crying with pain? Do you see that?

A. Yes. "Complains continually of pain, mostly

(Testimony of Dr. William R. King.)

the back; taking fluids better today." That was on the 14th at 9:00 a.m.

At 4:00 p.m. he was given Demerol for pain and restlessness.

On the 15th at 5:00 a.m.: "Crying with pain—restless."

The Court: I can read all that, Mr. Harr. He doesn't need to read it into the record.

Q. (By Mr. Harr): Doctor, what I was getting at is this: Patients differ, do they not? One can tolerate pain and another might not? A. Yes.

Q. Do you feel that this patient was of one type or the other?

A. I felt he required more sedation and medication.

Q. You remember Mr. Morin telling us about your talking with him about cutting his leg off?

A. Yes.

Q. Would you tell us about that?

A. I have no recollection of saying that to him. I won't [337] deny it, but he more or less quoted what I said as, "If you don't straighten out, I am going to have to cut it off." Whether that would be referring to the leg cast or something else, I don't know, but he was under narcotics most of the time there and we had difficulty in controlling him, and I might have said something like that.

Q. But at any time did you have any idea in the world of amputating the limb?

A. No. We felt he was coming along well.

Q. But because of his sensitiveness to pain he

(Testimony of Dr. William R. King.)

was a lot harder to take care of? A. Yes.

Q. Anywhere in the report is there any evidence that there was any infection?

A. No. The intern had made a note that the wound "appears to be infected," but we did not feel it was.

Mr. Harr: You may inquire.

Cross-Examination

By Mr. John D. Ryan:

Q. With regard to the narrative summary, you made that after the patient had been in the hospital, after discharge? A. Yes.

Q. You did not actually examine Mr. Morin when he came in the hospital? [338]

A. No, I did not.

Q. The question of threshold pain, it would take some observation to realize Mr. Morin did have threshold pain, as it is referred to?

A. Well, yes, but after the second operation I had charge of him then and had to cut down on his medication.

Q. Is there any doubt in your mind that during that period he was in actual pain?

A. I know he had pain, yes.

Q. An injury of this kind is accompanied by severe pain? A. Yes, sir.

Q. Is it true, Doctor, when a section is localized in the lower leg, or some part of the body, a rise in temperature is not always present?

A. That is true, but if the infection becomes at

(Testimony of Dr. William R. King.)

all deep then the temperature response would be noted.

Q. When did you first see the patient personally?

A. I would say probably on July 1st. My first note is made on July 5th.

Q. If you want to consult your notes, go ahead, but I have no further questions.

A. That is right. My first note was on the 5th, but I went on that service on the 1st of July.

Mr. John D. Ryan: No further questions. [339]

Redirect Examination

By Mr. Harr:

Q. I think Dr. Cherry yesterday said something about the fact that he was in a coma when admitted. Do you distinguish between that and being rather heavily sedated?

A. That is a difficult thing to distinguish. I think it is stated here, "Semi-comatose, hard to arouse."

Mr. Harr: I think that is all.

Mr. John D. Ryan: I have no further questions.

(Witness excused.) [340]

DR. PAUL WALKER

produced as a witness on behalf of Defendant, and being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Harr:

Q. What is your full name?

A. Paul Walker.

Q. You are with the U. S. Public Health Service Hospital in Seattle, Washington, are you not?

A. Yes, I am.

Q. Dr. Walker, will you state for the record where you graduated, where you took your medical education and where you interned and had your residency, and so forth?

A. Yes. I graduated from the University of Tennessee, College of Medicine, in 1931. I interned in the Baptist Memorial Hospital for 18 months in Memphis, Tennessee.

Q. You interned where?

A. Baptist Memorial Hospital.

Q. In Tennessee?

A. Yes, in Memphis. I had three years' residency training in surgery in New Orleans, Louisiana in the Marine Hospital. I had post-graduate training anatomy and pathology at the University of Maryland.

The Court: That is the school in——

The Witness: Baltimore. I was certified by the American [341] Board of General Surgery at Johns Hopkins in Baltimore in 1938.

(Testimony of Dr. Paul Walker.)

Q. (By Mr. Harr): Your specialty is general surgery?

A. General surgery, and I am Chief of the surgical service at Seattle.

Q. You are at the present time a consultant in surgery to the Washington Medical School, the University of Washington Medical School?

A. Yes, I am.

Q. How long have you been associated with the United States Public Health Service?

A. Since 1934.

Q. In the capacity of general surgeon, is that correct?

A. Well, I have been chief of that service since 1938; chief of surgery in Seattle and in various hospitals, Mobile, Louisville, on Navy transports during the war, and so on.

Q. You are presently in Seattle as Chief Surgical and Medical Director? A. Yes.

Q. Of the U. S. Marine Hospital there?

A. Yes, I am.

Q. You have been handed Plaintiff's Exhibit No. 3. Doctor, you have examined that record?

A. Yes.

Q. Since this case was filed? [342] A. Yes.

Q. And you are familiar with it? A. Yes.

Q. Would you refer to the record and advise the Court what part you played in the treatment of Mr. Morin as he went through that hospital?

A. Of course, I am in general supervision of the entire service. The way the service is set up, I have

(Testimony of Dr. Paul Walker.)

a deputy chief and two assistant chiefs, one of whom, the deputy chief, is my right-hand man, and my assistant chief, one of them, is in charge of orthopedics, and the other one is in charge of neurological cases. I make the rounds at periodic intervals and supervise these people, but they are qualified men under my supervision, four qualified men under my supervision.

Q. When you say "four qualified men"——

A. That means they have completed their residency in surgery, four to five years, and they have had from one to two years' experience under Board-qualified men, or Board men.

Q. What do you mean by "Board men"?

A. The Board is a group of surgeons who examine you to determine whether or not you are a qualified general surgeon. They are practicing in all specialties.

Q. This Board, is that a national organization?

A. Yes, it is an incorporated Board.

Q. You have been a member of the Board a great number of [343] years? A. Since 1938.

Q. Will you tell the Court what you know about this case and what you did?

A. Well, this man was admitted on June 12th to the hospital there, and I recall Dr. Wagner consulting me about this case. I am not positive that I saw him or not, but I did advise that he go ahead and do the debridement and reduction of the fracture, which was done, and the leg healed very nicely, and on the fourth operative day his temperature was

(Testimony of Dr. Paul Walker.)

normal. We rely very heavily on temperature to determine, to tell us whether or not there is infection present in the bone. We cannot see it any other way sometimes.

The sutures were removed on the tenth or eleventh day, I don't recall exactly which. At that time the wound was clean.

Five days later, the wound still being clean, we did a sliding bone graft and put in an Egger's plate, Egger's bone plate, to hold the bones in apposition. The reason we did this was because this was an oblique fracture; although it was not an acute oblique fracture—it was an obtuse oblique—sometimes those will heal by manipulation, but in his particular case it slipped and became displaced again, and we thought it was necessary to hold it in apposition, because this fracture of the leg had not united at the junction [344] of the middle and lower third.

Q. Why?

A. Because of the absence of nutrition existing in the lower end of the tibia at that point, and this frequently occurs, and nutrition of the bone is insufficient to carry on healing in a difficult fracture.

It had been a month, approximately, or three weeks at least, since the original injury, and since we had to do an open reduction and bring the bones, the bone ends, into apposition, and since the incidence of non-union is so high in such cases, we thought it was advisable to use a sliding bone graft to promote healing at the same time, which we did.

(Testimony of Dr. Paul Walker.)

Post-operatively, again, his temperature had run about normal—I should say, returned to normal within four or five days. It never had elevated to more than 99.2, which was unusual. They frequently do.

Q. Going back one step, Doctor, when you operated on him you said the wound was clean and well healed? A. Yes.

Q. You performed the operation, did you not?

A. Yes, sir; I did.

Q. At your direction there was a specimen taken? A. Yes, there was.

Q. Of a bony fragment or two? [345]

A. Yes.

Q. Those were sent to the pathologist?

A. Yes.

Q. Plaintiff's Exhibit No. 3 does have the pathologist's report? A. Yes, sir.

Q. Does the pathologist's report indicate that there was infection at that time in the wound?

A. This is the pathologist's report on the tissues submitted, bone chips in surgery. This was signed by Dr. Charles Keever who was the intern on the case. This was dated July 11, 1942, and on the 17th it states:

"Section reveals some bone of the bone chips which is definitely dead. There is some partially viable cortical bone and in some areas new bone is being laid down on top of dead bone. The larger piece of tissue representing callus shows some scar

(Testimony of Dr. Paul Walker.)

tissue. At one side of this tissue osteoid is being laid down. Cellular infiltration is at a minimum," and the impression of the pathologist is:

"Viable and necrotic bone fragments and callus from fracture site of tibia,"

and then in parenthesis: "Mal-union."

That is signed by the Associate Professor of [346] Pathology at the University of Washington Medical School, who is also the Chief Pathologist at the hospital. He is a Board man.

Q. You have discussed this case with him?

A. I took the tissue down to him after the case came up and asked him to review it, and he said there was no evidence of osteomyelitis in the tissue submitted.

Q. Would you go ahead and tell us about the significance of the temperature chart, what effect fever, for instance, might have and what it meant to you? Continue on, please.

A. Observation of the temperature curve is general. We look at the temperature curve, and if the temperature curve stays down, we don't disturb the wound, because it is a very good indication no infection is present. Any infection, in any degree whatsoever, will give you a temperature rise.

Q. Was there any significant temperature rise?

A. There was no significant temperature rise in this man throughout his hospital stay after the first four days or five days from the first operation and about four days from the second.

Q. Is there anything else in the report that you

(Testimony of Dr. Paul Walker.)

have there that you would like to comment on to the Court pertaining to this man's condition?

A. Well, I might go on to state that I have a note in my operative report, among other things, that this fracture could [347] not be closed or could not be retained by closed methods and, inasmuch as it had been three weeks since the original reduction of a compound fracture, it was decided that an open reduction with a bone graft would insure the most favorable conditions for union. The report states: "There was very slight callus present at the fracture site."

The skin was closed with a running lock stitch of dermal without difficulty. The extremity was put up in a plaster of Paris cast. There had also been a compression fracture of the second lumbar vertebra and the patient was placed in extension on a Roger Anderson table, which is an orthopedic table designed by Dr. Roger Anderson of Seattle.

Subsequently, at the time we removed the sutures there was considerable tension in the wound in the leg because the skin around the lower leg is scarce, and any swelling causes a considerable amount of tension in the skin and post-operative edema and swelling would cause some tension on the sutures, and with the spreading of the wound there was serous, which means just a fluid-like drainage from the wound and, according to one intern's report, there was some sloughing of the edges of the skin.

Q. Does that mean, Doctor, that there is actually infection present?

(Testimony of Dr. Paul Walker.)

A. No, sir; because whenever there is granulation tissue you always have serous drainage. [348]

Q. Granulation tissue, is that healing from the bottom up?

A. Yes, that is healing by secondary process; to heal skin to skin, that is primary. If it is healed by granulation tissue, that is secondary.

Q. Do you feel that the wound did heal satisfactorily after the operation you performed?

A. Well, yes.

Q. It was healing slowly, is that it?

A. Yes, we would like to have seen it heal more rapidly, but it was apparently doing satisfactorily when he left there because the temperature curve was normal and there was no evidence of infection.

Q. You think that is definite and positive, that there was no infection present or the fever chart would have risen? A. Yes.

Q. Go ahead, please.

A. I feel very definitely that there was no infection because of the lack of a rise in temperature.

Q. Mr. Morin left, of course, by his own choosing. Did that have the blessing of yourself and your staff that he should leave at that time?

A. No. There is a note in the chart that covers that. I don't know whether I ever talked to this patient before he left or not. I generally do, where a patient is apparently dissatisfied and wants to leave against medical advice, I try [349] to go down and tell him what the possibilities are, what he might

(Testimony of Dr. Paul Walker.)

expect, and try to urge him to stay on for a while for his own betterment, but whether I did that in Mr. Morin's case I don't know.

The Court: How many patients do you have?

The Witness: On the surgical service we have anywhere from 130 to 165 patients, and we have 1500 out-patients a month. There are nine of us—eight of us.

Q. (By Mr. Harr): You have been in the courtroom during the entire trial, Doctor, and you remember Mr. Morin testified that he just did not feel he was getting anywhere, I suppose on account of being away from home in Portland.

A. Well, I don't remember exactly about this particular case, but I believe it is covered by a note in the record, if you would like for me to read it.

Q. Doctor, I think that is perhaps taking up time. He did, however, make one significant statement, I thought. He said he thought he should leave there and get himself an orthopedist.

A. During the trial he said that, yes.

Q. I would like to have your views on that. That apparently is Dr. Cherry's view. Dr. Cherry, you remember, yesterday said some of these people undertake to treat patients when they don't know what they are doing, and made some other rather unkind remarks, and they should go to an orthopedic [350] specialist. What about that? I would like to have your views on that. Just tell us how you feel about that.

(Testimony of Dr. Paul Walker.)

A. Well, I don't agree with Dr. Cherry on that at all, and I could site you many teaching hospitals which do not have orthopedists running their fracture services. They have a general surgical service, and the orthopedic service is entirely separate. You call in an orthopedist when you have some complicated thing that they are familiar with, crippled children and crippled adults. In most communities, orthopedists are too busy to come out and fool with a fracture, and sometimes we can't get them out there. I realize, however, many general surgeons have made great contributions to the treatment of fractures in the past.

Q. You heard Dr. Leonard testify, and, without going over his testimony step by step, are you pretty much in accord with what he said?

A. You mean about——

Q. About the type of treatment.

A. Individual treatment of patients?

Q. Yes.

A. Certainly, every patient is a different individual.

Q. Well, would you go along with this, Doctor: A man comes in who is in extreme pain, with a fracture of the back, with a possibility of developing into an ileus, and a fractured leg. Is it not usual to accept the judgment of a good competent [351] doctor in attendance who can see him at first hand?

A. Yes, he would have to.

Q. He may be wrong; you concede sometimes

(Testimony of Dr. Paul Walker.)

that would be the case? A. Yes.

Q. But is that something that the general medical profession would, in your opinion, concede, that in these situations each case must be dealt with individually and left to the judgment of those who have seen him and know what his condition is at that time?

A. Yes, if they have competent backgrounds and have competent reasons for their judgment, yes.

Q. I think you have told me that where a man's general condition permits you would like to take him to surgery within six to eight or ten hours?

A. Yes.

Q. The sooner the better?

A. Although that deadline of six hours is pretty arbitrary, a pretty arbitrary deadline. Antibiotics have done wonderful things for surgery in general and fractures in general, as well. I cannot say arbitrarily six hours or five hours, or say that within five or six hours you are not going to get an infection and in six hours and one minute you are. Antibiotics have changed all that. You can see it evident in this particular case. [352]

Q. Would you have performed this operation with a bone graft and a plate if you had any idea that there was any infection?

A. No, sir; I would not. I would not perform a bone graft in the presence of infection; no, sir.

Q. I understand when Mr. Morin came down from Seattle that there was some slight angulation to the bone. I believe it will be shown it was five

(Testimony of Dr. Paul Walker.)

degrees; I think there is testimony on that, about it being about five degrees. A. Yes.

Q. Is that a poor result?

A. No, sir; that is not. Five degrees is not very much angulation. It would probably contribute very little additional difficulty, if any.

Q. If that wound were open and infected, as Dr. Cherry said, would it, in your opinion, have been good practice to manipulate that wound?

A. No, sir; I would not have manipulated it with that degree of angulation. One reason I would not have manipulated it is because if he already had an infection he was certainly asking for trouble by manipulating it under a general anesthesia, and it must have been quite a manipulation, because apparently considerable force was used. It had only been two months from the operation, from the time of the operation. There was definite callus [353] present.

Q. If there was infection in there, would it not activate it? A. It might, yes.

Q. If you were the doctor in attendance and it became necessary to remove the Egger's plate, and the wound was infected, and the infection extended down to the bone, and you removed the plate and screws, would you have sewn up the wound?

A. In that respect, I would be guided by the condition of the skin. If there was actual infection present, if the skin was thin and damaged, it would not hold the sutures anyway. If there was actually bone present and if there was an actual sequestra-

(Testimony of Dr. Paul Walker.)

tion of bone, I would have removed the sequestrum and left the wound open, and then got back at a subsequent date and done a skin graft.

Q. You heard how Dr. Cherry told about the operation, that he removed the plate after he had made the incision, and that he took out a small amount of pus, he said. Could that have been the cause of the sequestrum, the dead bone?

A. Dead bone is sequestrum. He had no culture done. He didn't really know whether it was infected or whether it was dead bone. Pus can be sterile; it can be infected pus. It does not have to have organisms in it to have pus, you know.

Q. Is that what you call a bony necrosis?

A. Necrosis means death. [354]

Q. I think Dr. Cherry testified that because of the fracture and the fact that it was reduced impaired circulation. Dr. Cherry said there was no circulation in the thigh, I think he said, and in the ankle.

Do you feel that a delay of, we will say, 40 hours in reducing the fracture would be the direct cause for reduction of circulation at that point?

A. I am not sure I understand your question.

Q. Dr. Cherry testified that because the fracture was not reduced that impaired circulation.

Mr. Thomas H. Ryan: The testimony was that the fracture was not cleaned. He did not say "reduced." That problem didn't come up. It was reduced later.

Q. (By Mr. Harr): He said early reduction

(Testimony of Dr. Paul Walker.)

would have prevented a failure of circulation in that area and damage to the circulation.

A. I believe he testified the man had adequate circulation in his ankles and he had adequate circulation in his thigh. There is only one blood vessel, one major blood vessel, that goes to the leg and that is the—if he had no circulation in his ankles, he had no circulation elsewhere, as far as efficient circulation around the fracture site was concerned. I would assume in this case he probably had increased local circulation if, as he states, he had infection.

Q. You have heard all the testimony thus far and you have [355] studied the history of this case, Doctor. Do you think it can be said, fairly and honestly, now, that the man's osteomyelitis resulted from this condition seven months before the osteomyelitis developed?

A. I do not think anybody could accurately determine when his osteomyelitis developed. He had originally an open wound; he had a secondary closure in Seattle; he had a third operation or a second operation with a bone graft and a bone plate; he had a manipulation. Any of those things could have caused his osteomyelitis.

The Court: How many other witnesses do you have?

Mr. Harr: I have just Dr. Hunter, Dr. Berg and Dr. Morrison.

(Recess until 1:30 p.m.) [356]

(Testimony of Dr. Paul Walker.)

(Court reconvened at 1:30 o'clock p.m., Friday, July 23, 1954, pursuant to recess.)

Direct Examination
(Continued)

By Mr. Harr:

Q. Doctor, I think I have to ask you one or two more questions. The plaintiff in this case, as you heard, was injured on June 10, 1952, and was able to return to work about the 8th or 9th of December of the same year, which would be a period of about six months.

Could you express a comparison of his case, his injuries, with the injuries of a similar nature that you have had in your experience? How does his case compare as far as being able to go back to work in that length of time; how does it compare with others that you have had in your experience?

A. Most textbooks will tell you that they can go back to work in about four to six months. Actually, in my experience, it takes considerably longer, an average of about eight months and the maximum generally is about twelve months before they are able to return to work.

Q. Are you also considering an injury along with the compound fracture, also a fracture of the back?

A. I was not considering the fracture of the back in that, no. The time for a fractured back is generally eight to twelve [357] months, but with

(Testimony of Dr. Paul Walker.)

multiple injuries it might prolong his return. Bone heals generally within six months or so; sometimes it does not; sometimes there is associated with an injury trauma to the muscles and prolonged immobilization of the joint, and the patient is just not able to walk without a cast and go back to work. It takes time for him to rehabilitate himself and build up his strength and increase his joint motion.

Q. One more question along that line: There has been some little comment made thus far as to economy. It has been suggested or at least inferred that economy was the only reason for this treatment not having been given in Portland, the man being sent to Seattle, that economy was the only reason. What has been your experience in the years you have been with the Public Health Service, in Seattle, I think you said, and New Orleans and elsewhere, with reference to economy in treating a patient? Just give us your general view of that.

A. Well, it is quite true the Public Health Service treats its patients cheaper than any of the other service hospitals—I am talking about the armed services or the Veterans Administration—but at the same time I believe our equipment and our service to patients is as good as any of these services, or any other place. If I did not feel that way, I would not stay in the service; they don't pay me [358] enough money; they have to give me good equipment and good things to work with for the patients' care.

Q. And you did have good equipment and a good staff in Seattle, did you not?

(Testimony of Dr. Paul Walker.)

A. We have an excellent staff and we have excellent equipment, yes.

Q. You made a statement to me which impressed me about the matter of a patient complaining of pain when in a cast. Tell the Court just what you told me about that.

A. If a patient tells me he is having pain, I talk to him and look him over and see if there is any cause for his pain. If there is any question in my mind, I will take the cast off, rather than have him suffer or complain unduly. There may be something in the cast I can't see from an external inspection, so I will bi-valve his cast and look at it and inspect it and see. I do that to protect the patient, because you are not always right; the patient sometimes is right, certainly.

Q. But when it comes down to the question of economy——

A. Economy has nothing to do with it.

Q. Have you ever heard of them practicing economy at the expense of the patient's health and welfare?

A. Economy has nothing to do with it at all; no, sir.

Mr. Harr: You may inquire.

Mr. John D. Ryan: No inquiry. [359]

The Court: That is all.

(Witness excused.)

DR. ALBERT T. MORRISON

produced as a witness on behalf of the Defendant, and being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Harr:

Q. Your full name, Doctor?

A. Albert T. Morrison.

Q. You are with the Public Health Service?

A. Yes.

Q. You are in charge in Portland, Oregon, at this time, and have been for some time past?

A. Yes.

Mr. Thomas H. Ryan: Talk a little louder, please.

Q. (By Mr. Harr): Would you state for the record where you got your training, what schools you attended and where you interned, and generally what your educational qualifications are?

A. I finished the University of Oregon Medical School and interned in Multonomah County Hospital in Portland; then I went into the Public Health Service and spent about twenty [360] years total in hospital work. I finished school in 1922, so I have had about 32 years——

Q. 32 years' practice? A. Yes.

Q. During that 32 years have you been with the U. S. Public Health Service all that time?

A. Nearly 30 years.

Q. At the present time you are in charge of the patients here in Portland, patients of the Public

(Testimony of Dr. Albert T. Morrison.)

Health Service? A. Yes.

Q. Were you employed in a similar capacity in June of 1952? A. Yes.

Q. As I understand it, you did not go to the hospital or treat the plaintiff in this case, Amos Morin? A. No.

Q. You did not see him until later when he got out of the hospital in Seattle, is that right?

A. Yes.

Q. Do you recall discussing the case with Dr. Craig and Dr. Leonard and determining that the case was one that should properly be sent to Seattle?

A. Yes.

Q. Will you tell us about that.

A. Well, as soon as I heard that this patient was in the hospital, we were quite aware of the serious nature of his [361] injuries and we made sure that Dr. Leonard was on call and had taken over the case.

Then, the next day, we got the report of the case from Dr. Craig and in the afternoon reached Dr. Leonard by telephone and inquired what he thought of the case, and it was our opinion, between the three of us, that with the multiple injuries and probably prolonged treatment required, he would be better off if he were in the Seattle hospital to begin with, and since the immediate emergency was over and that he would not be operated on any sooner in the Physicians and Surgeons, and that the trip to Seattle was not considered to be hazardous in

(Testimony of Dr. Albert T. Morrison.)

any way, we determined that we would transfer him to Seattle.

Q. I notice in one of the reports that was made, I think over your signature, it was indicated that the reason he was being transferred was for reasons of economy. Tell me, did you write that report?

A. No, the doctor who had charge of the case prepares the transfer papers and the abstract of the record and presents it to me and I sign it.

Q. Do you have any remarks to make as to why that comment was made?

A. Yes, I think that I should comment. This procedure of transferring patients to Seattle is routine for many ambulance patients and for surgical cases where they are convalescing [362] post-operatively and are able to make the trip, not for reasons of economy in the first place but because they have better facilities in Seattle than in most general hospitals for looking after such patients, and they have a fine physiotherapy department there which is important in rehabilitating any fracture case.

Of course, you may say that economy enters into these routine transfers. We have orders that that shall be done, but in this particular case this was not regarded as a case in which economy entered into it whatsoever.

Dr. Craig prepared the papers and, somehow or another, got this statement in there. It was late in the day when I received it; the clerks had gone home; so I was rather taken back to see that on the

(Testimony of Dr. Albert T. Morrison.)

papers, but, since it was difficult to get it rewritten, I simply signed it and put it through, although it was contrary to the facts. There was no idea of economy in this transfer whatsoever. It was simply that the welfare of the patient would be enhanced if he were sent to Seattle.

Q. Have you ever considered economy when the welfare of the patient is to be considered?

A. No, there is no reason why we should, in the Public Health Service.

Q. Of course, in the outlay of public funds and appropriations, that does necessitate that you be economical if you [363] can.

A. The system that the Public Health Service has for hospitalization—they have a number of large hospitals very well equipped and very well staffed at central locations around the country, and then in the other cities in the neighboring states they have found it best to have clinics located, and they are supposed to make these transfers of any suitable cases to the hospital, the Public Health Service hospital. That has been the policy for many years, and we have found that it works out all right.

Mr. Harr: You may inquire.

Cross-Examination

By Mr. John D. Ryan:

Q. When did you first learn Amos Morin was injured and was at the hospital?

A. They called the clinic where Dr. Craig is located shortly after he arrived there.

(Testimony of Dr. Albert T. Morrison.)

Q. The Physicians and Surgeons Hospital on June 10th did that, on the day he was brought into the hospital? A. Yes.

Q. Were you informed at the same time?

A. Yes.

Q. Were you told what his injuries were?

A. Yes. [364]

Q. Is Dr. Kimberley a consultant of your service in Portland, Oregon? A. Yes.

Q. Is Dr. Kimberley an orthopedist?

A. Yes.

Mr. John D. Ryan: That is all.

Redirect Examination

By Mr. Harr:

Q. Do you know whether or not Dr. Kimberley was a consultant at that time?

A. Oh, yes; he has been a consultant for quite a number of years.

Mr. Harr: That is all.

(Witness excused.) [365]

DR. WARREN C. HUNTER

produced as a witness on behalf of Defendant, and being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Harr:

Q. You are Dr. Warren C. Hunter?

A. Yes.

(Testimony of Dr. Warren C. Hunter.)

Q. Will you state generally your education, your schooling and qualifications?

A. Well, I was graduated from the University of Oregon Medical School——

Mr. Thomas H. Ryan: We will admit the doctor's qualifications.

A. (Continuing): ——I received my degree of Doctor of Medicine in 1924. Prior to that time I had been a student instructor in pathology.

After a year's internship, I went into pathology as a specialty and have continued in that ever since.

Two years later, 1927, I spent one year at the University of Michigan in graduate work and for a Master's degree in pathology. From there, then I returned to Portland and have been engaged in consultative practice and teaching pathology in the Medical School ever since. I have been head of the Department of Pathology since 1944.

Q. I will ask you whether or not you did not, at the request [366] of Dr. Morrison of the U. S. Public Health Service, examine a specimen of tissue and bone fragments?

A. I examined a slide with some microscopic sections on it, stained sections, at his request, yes.

Q. You have been shown Defendant's Exhibit No. 17. I will ask you if that contains the specimen that you examined?

A. It bears the same number, S-52-1702, Amos Morin. This slide has on it some number of microscopic sections that my report indicates I saw. The

(Testimony of Dr. Warren C. Hunter.)

chief identification, of course, is the number, S-52-1702, and the name "Amos Morin."

Q. Did you make a report of your findings and conclusions after having made a microscopic examination of that exhibit? A. Yes, I did.

Q. Would you tell the Court what your findings were?

A. This report was dated April 13, 1954. In addition to the number and the name and Dr. Morrison's name, there is a brief description of the slide saying that it has five sections on it, what they have been stained with, and so forth.

The examination, microscopically, indicates that four of these tissues on the slide are bone, each with a very little marrow along with it, and in neither one of them could I see inflammation or necrosis or a breakdown either of the bone or marrow.

The fifth and much the largest of the pieces [367] of tissue was not made up much of bone; it consisted mostly of connective tissue and fat although at one edge of it there was a little callus, which is evidence of healing bone, and some young trabeculated bone, a little bit of bone which was surrounded by or imbedded in the connective tissue.

This little bit of buried bone I did not feel was broken down or necrotic, but its position made me think that it might represent a tiny sequestrum from the fracture site—a sequestrum, as it is called, or a little cast-off piece from the fracture site.

There were few leukocytes, or wandering cells, present. They were of two kinds, what we call monocytes and, the other, lymphocytes, foreign-body

(Testimony of Dr. Warren C. Hunter.)

types of cells which are likely to surround any inanimate matter that cannot be discharged, all of these lying in the connective tissue, but these were the only evidences of inflammation existing at all in any of the tissues that are on this slide.

Some of this connective tissue showed evidence of having been recently formed. At one point a few skeletal muscle fibers had become incorporated in the connective tissue.

The question that was asked of me by Dr. Morrison was whether in my opinion there was evidence of infection in this tissue, and my answer was no; there was but little inflammation [368] at all and this is not the type of reaction that one would expect to an infectious agent; that is, some form of bacteria.

Q. Doctor, it has been testified that these specimens were taken deep in the incision that was made, where there was a sliding bone graft and an open reduction of the fracture, with a metal plate applied.

A. Well, Dr. Morrison told me, when he delivered this microscopic section to me personally—he told me that these tissues had come from the site of a compound fracture to a lower extremity some little time after the fracture occurred, and that these were removed at the time of an open reduction of the fracture.

Q. So, if there was infection there, you would have expected it to show up in this specimen, would you not?

A. Yes, if the specimens had been properly taken

(Testimony of Dr. Warren C. Hunter.)

in sufficient number, and they seemed to be; there were five of them.

Q. Osteomyelitis, of course, is an infection, is it not?

A. It is an infection of the marrow of the bone.

Q. You, of course, found no evidence of osteomyelitis being present in these bone fragments?

A. No, I didn't.

Q. There is a practice, of course, in hospitals to make a submission of tissues, to submit tissues to the laboratory, [369] when operations are made. Is that not correct?

A. It is almost universally done, yes.

Q. What is the purpose of them taking these specimens?

A. It has more than one purpose. One purpose is simply identification, to better the practice of medicine, to see whether another doctor can identify the tissue that is purported to have been removed. That is among the purposes, as an exact diagnosis is most important, the most important purpose of all in submitting material of that kind, to submit anything that you remove operatively to the pathologist, whose business it is to know what is abnormal, and he asks anyone to consult with him and ask his opinion: "What is it? What is wrong with it?" and that is an independently rendered opinion by another person, who then makes a written report and concludes his report by what is known as a pathological diagnosis as distinguished, for example, from a clinical diagnosis.

(Testimony of Dr. Warren C. Hunter.)

Q. Doctor, we are here dealing with a patient who, in addition to a fracture of his back, sustained a rather bad compound fracture of his left tibia, the lower third. It appears that sometime later, perhaps six or seven months after the accident occurred, osteomyelitis developed.

Would you advise us the most common source of osteomyelitis infections?

A. Well, in a compound fracture, by which we mean a fracture [370] in which some portion of the broken ends of bone actually protrude through the soft tissues and through the skin to reach the surface where they can be seen to produce a wound, in such a fracture, any such a fracture, I should say, has possible infection in it and, since then that might be an infection of the bone, then osteomyelitis can be directly attributable to contact with the bacteria that are on the skin and in the skin at the time the bone protrudes through it.

In such an event, I would expect the osteomyelitis, if it developed, to make its appearance quite early or promptly and not months later.

Another circumstance under which osteomyelitis can develop is without any fracture at all, even without any injury, and have the bacterial organisms or germs come through the bone by way of the bloodstream and eventually reach the marrow of the bone and start an infection and produce osteomyelitis.

Q. If a wound were to heal by first intention, within a relatively short period of time, within

(Testimony of Dr. Warren C. Hunter.)

three weeks, and there is no fever, no swelling, no redness, would you then feel that there was osteomyelitis? A. No, I would not.

Mr. Thomas R. Ryan: I think he ought to relate the subsequent history of this thing, if he is going to ask a [371] hypothetical question.

The Court: Let him ask it in his own way. Go ahead. He said no, he would not.

Q. (By Mr. Harr): If there were an infection present in that wound before it was closed, you say you felt it would appear in a relatively short time. Do you think it would appear within three weeks' time?

A. I would expect it to appear right away after failure of union to occur and after failure of the wound in the skin to heal.

Q. Would that be particularly true of the tibia, that close to the surface?

A. The tibia has a bad reputation in that respect. That is all I can say. I am not too familiar with it. I would say in general in any compound fracture I would expect that to happen. I know clinically the tibia does have a bad reputation in that regard.

Q. Following the three-week period I spoke of, this man being injured on June 10th, I believe on July 11th there wasn't good union and the fragments had not healed and it was determined that he should have an open reduction at that time, and that operation was performed, and there was a sliding bone graft made and an Egger's plate applied.

(Testimony of Dr. Warren C. Hunter.)

I will ask you whether or not, regardless of the type of care that was given, whether or not through that [372] operation osteomyelitis and infection could have been injected into the wound?

A. I think one must admit that every time a wound is opened, every time the tissue is exposed there is at least opportunity for infection to take place.

Q. Following that, the wound healed slowly, and in August, about the middle of August, the patient left the hospital, and then he had some angulation, about a five-degree angulation of the tibia; the bone, although it was healing well, it seems, was manipulated by a closed reduction to straighten it more.

Would that be a possible cause of osteomyelitis when you add to that the fact that at the time there is supposed to have been an open wound with some drainage?

A. I am to assume that there was still an open wound with some drainage at that time?

Q. That is the testimony, yes.

A. Yes, conceivably that might happen, that any manipulation of the injury might be done that might make the infection more likely.

Q. If there was infection there, would that manipulation in itself be likely to activate it?

A. It is entirely conceivable, yes.

Q. In November, the latter part of November, the evidence is that the wound was entirely healed and that the bone was [373] solid.

Would you expect osteomyelitis to be present in

(Testimony of Dr. Warren C. Hunter.)

that fracture at that time in the light of that history? A. No, I would not.

Q. If there were a fracture site such as this, healing, and the wound closed, and if a person had a focal infection, such as sinus trouble, would that be carried by the bloodstream and be a possible cause of osteomyelitis?

A. Yes, it might be; one does not have to have a compound fracture in order for osteomyelitis to develop, when it comes to the bloodstream, an infection in some other part of the body.

Q. After having had an operation and being treated, as I have described, is the existence of a fever or the lack of a fever a sign as to whether or not there is infection in the system?

A. We always look upon fever as evidence that something is wrong and we start looking for the source of it, and infection is one of the causes of fever, yes.

Q. If a man is in the hospital, we will say, from June 14th until the middle of August, a little over two months, and his fever stays stable with very little variation, would you expect there to be infection?

A. You said his "fever" stays stable. Did you mean that?

Q. His temperature. [374]

A. By "fever" I would refer to something above normal.

Q. His temperature. A. His temperature?

Q. Yes.

(Testimony of Dr. Warren C. Hunter.)

A. That is, of course, different. If the temperature stayed normal——

Q. Relatively normal.

A. What do you mean by "relatively normal"?

Q. I believe you could say it stayed normal.

A. I would say that there is no evidence of infection under those circumstances.

Mr. Harr: I think you may inquire.

Mr. John D. Ryan: We have no questions.

(Witness excused.) [375]

DR. RICHARD F. BERG

produced as a witness on behalf of Defendant, and being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Harr:

Q. Doctor, you are a duly licensed surgeon, physician and surgeon, in the State of Oregon, are you not? A. Yes.

Q. Will you state your qualifications?

The Court: Would you give him the same stipulation he gave you?

Q. (By Mr. Thomas H. Ryan): Yes.

Q. (By Mr. Harr): Did you examine Mr. Amos Morin? A. Yes, sir; I did.

Q. You were given the history of the patient, I believe, of having had a back fracture and a compound fracture of his lower left tibia?

A. That is right.

(Testimony of Dr. Richard F. Berg.)

Q. What was the history that he gave you, Doctor?

A. Well, I saw this gentleman on the 8th of March of 1954. He gave me a history of having suffered an accident on the 10th of June, 1952, when he had fallen from a ladder at his home, suffering injuries to his back and a compound fracture of his left leg. He informed me he was taken to the Physicians and Surgeons Hospital; he received first-aid treatment; and [376] his leg was splinted, and X-rays were taken of his back and leg.

Then he informed me that about two days later he was transferred to the Marine Hospital in Seattle where an open operation was done on the fracture of his leg, open reduction.

About a month after that had been performed the cast was opened by a window and the wound was inspected but, due to the delay in growth, a bone graft was performed. He stated he was in the hospital about 16 weeks and he then came to Portland and he was under the care of Dr. Cherry, and in January of 1953, he was taken, I believe twice, to Providence Hospital and once to St. Vincent's, the first time for manipulation and then later he had the plate which had been previously inserted in Seattle removed, and in February of 1953, he had an acute inflammatory process for which he informed me he was treated at the St. Vincent's Hospital with hot packs, and then, due to the fact that there appeared to be rather extensive and prolonged treat-

(Testimony of Dr. Richard F. Berg.)

ment, he was transferred to the Veterans Hospital here, where he received continuous treatment for a considerable length of time, and had several skin grafts for skin lacerations—I think he had 12 or 13 operations in all on his leg.

The past history that he gave me was essentially negative [377] for injuries, operations or serious illnesses. He had been treated for a peptic ulcer about four years previously. I think that is the main part of the history.

Q. I think the history he gave you is substantially correct. He was in the hospital from June 12th until August 13th or 14th.

A. Yes.

Q. Which was about eight or nine weeks?

A. Yes.

Q. Doctor, to bring you up to date on that, I think it has been shown that he was taken to the Physicians and Surgeons Hospital at about 1:15 on June 10, 1952; that there he was taken to the emergency surgery and given a cursory examination, his trousers were removed, and he was suffering severe pain and he had, for that pain, been given a shot—he had been given a shot of some kind before ever leaving his home; a doctor had been called to his house and had given him this shot of morphine.

He had fallen perhaps 10 feet by the side of his house; he had been on a ladder and the ladder slipped and he fell, and his leg got caught in one of the bottom rungs of the ladder.

The ladder was removed; a blanket was put over

(Testimony of Dr. Richard F. Berg.)

his leg, and he then was transferred by ambulance to the Physicians and Surgeons Hospital where, after a cursory [378] examination and after his trousers had been removed, the wound was cleansed by a mild antiseptic solution and detergent, and it was observed there were two lacerations, one an inch and a half and one about an inch, and after the antiseptic and detergent were applied to the outer edge of the wound, then a saline solution was poured in the wound and over it, and the wound was then covered by a compression bandage and splintered and Ace bandages applied.

Then he was taken to the X-ray and his back and his legs were X-rayed, after which he was taken to his room and his back put in extension and his leg elevated on two pillows.

Assuming those facts to be true, would you, in your opinion, consider that to be suitable treatment by doctors, average doctors in this community and like communities?

A. Yes, as far as you have stated it, I think it is.

Q. At that time he was given penicillin, his blood was typed and cross-matched, blood plasma made ready, and his blood pressure taken; his temperature was 99.2, blood pressure 140 over 88, upon his admission.

Then his pulse increased a little bit so that at 4:00 o'clock the morning of June 11th it was up to 112; his temperature had gone up to 99.6 in the afternoon of June 11th, and a little later the temperature was 100.2. An ileus [379] developed and

(Testimony of Dr. Richard F. Berg.)

his abdomen was distended. He had to be catheterized, and during all of this time he had been in very severe pain in his back and his leg; he was given Deprapanex and received Dromaron on June 10th, to relieve pain and was also given Sedamyl; and then at 8:00 the morning of June 12th, his condition having been considered then to be stable and he not having gone into shock, he was transported by Arrow ambulance to the U. S. Public Health Service in Seattle.

I would like to mention that while he was in the hospital he was given glucose intravenously.

On the trip to Seattle there was an attendant besides the driver of the ambulance. They were with him during the entire trip to Seattle. A. Yes.

Q. Would you say that that was the type of treatment that could ordinarily be expected to be administered at a hospital in this community or like communities by doctors possessed of ordinary skill and diligence?

A. In answering that question, I would say that each individual case is a specific problem. Ordinarily, we like, if we can, to keep our patients quiet until they have overcome any possibility of shock. In this instance, of course, you have two main things to consider, the fractured spine and the compound fracture of the leg, as well as abdominal [380] distention and danger of ileus. Those are common things you expect every time you have a fracture.

Under the circumstances, I would say, inasmuch as there was no possibility of openly reducing the

(Testimony of Dr. Richard F. Berg.)

fracture or continuing the treatment of this man in the present locality, that under those circumstances I see no fault in that at all, in the manner in which it was handled.

Q. With a patient in a hospital, suffering those injuries, is it not a fact that ordinarily doctors give first consideration to a man's general welfare, his general condition?

A. I think every doctor should, yes.

Q. I think it has been developed that this particular patient had a low threshold for pain and he had been suffering more as a result of this at the time of his entrance to the hospital, but I don't suppose his attending physician knew that at that time. He had a difficult problem presented to him. But, isn't it true that the doctor treating the case was, so to speak, in on the ground floor, and isn't it normal he would be expected to know what should be done for the patient?

A. Well, a qualified man, I would say, should have a little better insight into it than someone who had not seen the circumstances. As I stated, every case presents a different situation, and it is hard for me to sit here and put the finger on someone whom I did not watch do the work. Based on general [381] experience, as I say, I see nothing to be criticized in that treatment.

Q. What would be the effect of a general anesthetic if a man was in incipient shock?

A. Well, of course, you don't like to add further shock to him. Anesthesia is a shock, too.

(Testimony of Dr. Richard F. Berg.)

Q. You were in the courtroom when Dr. Hunter was testifying and stated that, in his opinion, if there was infection in this wound it would normally have developed rather rapidly?

A. As a rule it does, yes.

Q. Do you subscribe to that?

A. Yes, sir; I do.

Q. I think the evidence has been that within three weeks after he arrived at the Seattle, Washington, hospital his leg was entirely healed, that is, the wound was entirely healed, but there was crepitation which existed from the operative procedure. In the absence of any fever and the wound being healed, would you consider that there was any infection in the fracture site?

A. Well, I don't think you could assume that there was.

Q. There are many causes, are there not, of osteomyelitis? A. Yes.

Q. Without repeating the testimony, would you subscribe generally to what Dr. Hunter testified as to the sources of osteomyelitis? [382]

A. Yes, I think he stated it quite concisely.

Q. Are compression fractures usually quite serious, quite painful?

A. Yes, they are as a rule, in the lumbar region, in the dorsal area. Lumbar fractures are painful.

Q. When you have a compression fracture and also a compound fracture of the leg, isn't that situation fraught with danger, I mean as to shock and ileus?

(Testimony of Dr. Richard F. Berg.)

A. Practically all of your fractured spines have some ileus, unless you treat them by relaxation and medical beforehand. That is one of the sources of a great deal of discomfort and trouble. Of course, a leg fracture is painful in any event.

Mr. Harr: I think you may inquire.

Cross-Examination

By Mr. Thomas H. Ryan:

Q. You would consider a compound fracture of the lower third of the tibia more or less a serious situation?

A. Yes, I do. I think that compound fractures any place are an emergency.

Q. Isn't that particular portion of the tibia particularly dangerous, when there is a fracture of that type?

A. There are, in any portion of the tibia, either the upper part or the lower third. [383]

Q. Isn't it ordinarily the practice to go in and clean and debride the wound as quickly as possible?

A. According to our teaching and from the books, that is the thing to do, but, as I said, there are instances where your judgment, after evaluating the situation, looking over the situation, sometimes you defer very active or intensive work.

By "debridement" maybe I mean something else than you do. Debridement is quite an extensive and detailed piece of work. We have to be careful of the nerves and of the blood vessels. Sometimes——

(Testimony of Dr. Richard F. Berg.)

Q. You generally do that right away, don't you?

A. Yes, try to do it right away.

Q. Ordinarily, if you are called in on a compound fracture of that type, do you wait until the next morning before you visit the patient, if you are called, say, in the afternoon?

A. Not ordinarily. I like to do it just as soon as I can.

Q. You would not wait until 11:00 o'clock the next morning to go over to see the patient, ordinarily?

A. Not unless I was pretty assured he was all right and that he had been taken care of.

Q. What about exposure of the wound?

A. Well, there again we run into two schools of thought. In the early days we would have been very much criticized for closing any open wound. Nowadays we close them because [384] we have antibiotics, although you do not have to necessarily suture them, if you put some form of dressing on and cleanse them. They are continuously filling in, you know.

Mr. Thomas H. Ryan: That is all.

Mr. Harr: That is all.

(Witness excused.)

Mr. Harr: The defendant has no further testimony.

The Court: Any rebuttal?

Mr. Thomas H. Ryan: No rebuttal.

(Argument of counsel.) [385]

August 19, 1954

PLAINTIFF'S TESTIMONY AS TO ATTORNEY'S FEES

JOHN D. RYAN

produced as a witness on behalf of Plaintiff, being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Thomas H. Ryan:

Q. You are John D. Ryan, an attorney?

A. Yes.

Q. You represent Amos Morin, plaintiff, in a case against the United States of America?

A. Yes, sir; I do.

Q. When did you become his attorney in that matter?

A. I was retained by Mr. Morin the 13th of February, 1953. [386] At the time Mr. Morin came into my office, he informed me he had had an injury to his leg that he felt was aggravated by the treatment he received, and at that time we were not certain who the defendant would be because there were both the individual doctors, the hospital, and the United States Government involved.

Mr. Morin at that time was asked by me whether he had any funds with which to retain me and he said no. At that time I explained to him the possibility of handling the case on a contingent basis, which I did, and subsequently, when it was deter-

(Testimony of John D. Ryan.)

mined the United States Government was a proper party, a proper defendant, I explained to Mr. Morin the nature of the Federal Tort Claims Act and the nature of a contingent case under that Act, and the fact that the fee would be set by the Court at the completion of the trial in the event we were successful; in the event we were not successful, he would owe me no money for my services.

The Court: How much did you contract for before you found out the case came under the Federal Tort Claims Act?

The Witness: I followed the minimum bar fee, the schedule of the Oregon State Bar, of 25 per cent if a settlement was made prior to filing, one-third for settlement after filing and before trial and 40 per cent in case of a trial.

The Court: Who puts up the money for expenses?

Mr. John D. Ryan: The client. [387]

The Court: Suppose he does not have it?

The Witness: If he does not have it, we would make the advance.

Q. (By Mr. Thomas H. Ryan): Did you arrange to get medical testimony in this case?

A. I did. I interviewed one of the treating doctors regarding this case and several other physicians of my acquaintance for the purpose of corroborating him, and that was the basic problem of the case.

I had a number of conferences with Dr. Cherry at the time I undertook the case—I would say there were three in all—to determine the validity of the

(Testimony of John D. Ryan.)

claim being made from a medical standpoint, prior to preparing my complaint.

At the same time I did considerable research or had considerable research to make as to the basis of the cause of action, just what the cause of action would be against the Government, and it was determined it was a tort case under the Federal Tort Claims Act. My conferences on the medical evidence continued up until the time of trial.

After the preparation of pleadings, I had to confer with doctors on several other points of interest, as far as I was concerned, due to possibility of settlement, in order to endeavor to convince the U. S. Government of the validity of the case. [388]

Then, at the time when the trial of the case became certain, I had further conferences with Dr. Cherry, in April and May of this year; I had three separate conferences with Dr. Cherry regarding preparation for depositions taken of Dr. Craig and Dr. Schneider, the nature of the questions to be asked, concerning hospital procedures and treatment. That is about the extent of my conferences.

Q. Did you do any research in the medical field yourself?

A. Yes. I was assisted by Dr. Cherry, after having been given some texts, Campbell's "Operative Procedures" and the Pictorial Handbook on fracture treatment, which I read. I also had and read other books on medicine and fractures, and particularly Christopher's "Operative Orthopedics."

(Testimony of John D. Ryan.)

The Court: Did you ever have a proposition for settlement?

The Witness: I never had.

The Court: Did you invite one?

The Witness: I did ask if there was a possibility of settlement and was informed that there was not.

Q. (By Mr. Thomas H. Ryan): You took that up with Mr. Harr?

A. I took that up with Mr. Harr.

Q. I also have cooperated with you throughout this case?

A. You have cooperated with me, yes, and particularly in the time of the preparation of the case when you assisted me in determining the method we would follow. [389]

Q. Ordinarily in a case like this you would have followed the Bar fee?

A. We do that in the usual case, yes.

Q. You were in court here three days and then another half-day for argument?

A. That is correct.

Mr. Thomas H. Ryan: No further questions.

The Court: Do you have some questions?

Mr. Harr: No, your Honor. [390]

JAMES LANDYE

produced as a witness on behalf of the Plaintiff, being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Thomas H. Ryan:

Q. Your name? A. James Landye.

Q. Your occupation? A. Lawyer.

Q. For the record—I know the Court knows who you are—would you tell what positions you have held with the State Bar and the local Bar Association?

A. I have been President of the Multnomah County Bar and a member of the Board of Governors of the State Bar.

Q. Are you familiar with the fee ordinarily charged on a contingent basis in a malpractice case in this city and state? A. Yes.

Q. What is that?

A. It runs the same as the others, 25, 35 and 40 per cent.

Q. You heard Mr. Ryan's testimony. Would you say that would be a reasonable fee in this type of case?

A. Yes, I would say in a malpractice case 40 per cent would be a reasonable fee.

The Court: If a fee is allowed here, the maximum permitted [391] by the statute is 20 per cent.

The Witness: In the absence of a statute, I would say 40 per cent, but, as the statute only provides for 20, I would say 20 per cent is the minimum.

(Testimony of James Landye.)

The Court: I wonder if anybody knows what has been the practice in the District Court in connection with Federal tort claims, whether it has been the uniform practice to allow 20 per cent. I don't know. I have been doing it, but I don't know what the other judges have been doing.

Mr. Thomas H. Ryan: I understood, just by hearsay, that was the practice.

The Court: Uniformly, after trial?

Mr. Thomas H. Ryan: I understand so, now. I don't know. I was told by someone.

The Court: Any questions?

Mr. Luckey: No questions.

(Witness excused.) [392]

DONALD H. JOYCE

produced as a witness on behalf of the Plaintiff, and being first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Thomas H. Ryan:

Q. You are Donald H. Joyce? A. Correct.

Q. What is your occupation?

A. An attorney.

Q. Are you acquainted with the fee ordinarily charged in a malpractice case in Oregon?

A. Yes. Most lawyers in this locality go by the minimum Bar Schedule, 25 per cent if the case is settled before filing; 33⅓—or 35; some charge 35—

(Testimony of Donald H. Joyce.)

if it is settled after the action is brought; and 40 per cent after trial.

However, it is the practice of many lawyers in a malpractice case to charge a fee above the minimum proposed fee as set by the Oregon State Bar, because it is a difficult case to try and a difficult case to win.

Q. Have you had any cases under the Tort Claims Act? A. I have.

Q. In this Court?

A. I tried one here about two and a half years ago in this very courtroom before the Honorable Gus Solomon.

Q. What was the fee allowed? [393]

A. The fee allowed there was 20 per cent.

Q. Considering the verdict was $45,000 general damages and $4,711 special damages, what would you say would be a reasonable fee in that type of action described by Mr. Ryan?

A. I can see no difference in this case from any other type of damage action. I am aware of the limitation imposed by the Tort Claims Act of 20 per cent. I think the maximum should be the minimum in this type of action. The only justification for that fee of 20 per cent I would say that here we have a solvent defendant where you can collect the judgment.

The Court: In a malpractice case it is hard to get doctors to testify against each other. Isn't that one of the problems?

Mr. Thomas H. Ryan: It is a big problem.

(Testimony of Donald H. Joyce.)

The Witness: It has been necessary for me to take nonsuits before trial because the doctors run out on me.

The Court: Strictly speaking, I don't know whether you can do it with a malpractice case or not, as this case arises under a special statute. There is another statute, however, that has to be kept in mind. This action arises under a statute which makes it the duty of one of the agencies of the Government, the Public Health Service, I believe that is the name, to provide adequate medical service and hospital care for seamen. That is a [394] statutory duty. That is an overriding duty, over and above the obligation that a service takes when a plaintiff comes into this Court. I don't know whether that subject has ever been explored or not, but that would affect the standards of the Court to be observed. It has been in my mind all throughout this case.

As to this particular question, it seems to me it would be good practice for you to offer additional findings of fact which could be in very few words. Our rules permit additional findings to be presented. I don't know whether you are within time or not. Maybe the limit is ten days.

Do you have any questions?

Mr. Luckey: No questions.

(Adjournment.) [395]

Reporter's Certificate

I, Ira G. Holcomb, an Official Reporter of the above-entitled Court, do hereby certify that on the 21st, 22nd and 23rd days of July, 1954, and on the 19th day of August, 1954, I reported the proceedings had in the above-entitled matter, that I thereafter caused my said shorthand notes to be reduced to typewriting under my direction, and that the foregoing transcript, consisting of Pages numbered 1 to 395, both inclusive, constitutes a full, true and accurate transcript of said proceedings so reported by me in shorthand on said dates, as aforesaid, and of the whole thereof.

Dated at Portland, Oregon, this 28th day of September, 1954.

/s/ IRA G. HOLCOMB,
Official Reporter.

[Endorsed]: Filed October 11, 1954. [396]

EXHIBIT NO. 12

DRS. BLAIR, THATCHER & DAVIS
STANDARD INSURANCE BUILDING
PORTLAND 5, OREGON

NAME MORINAmos R. No. [illegible] DATE 8/24/52/ at Prov. AGE 44 yrs.
ADDRESS
RES. 4640 N.E.30th PORTLAND
BUS. U.S.Engineers, Dredge Worker REFERRED BY Dr.J.Thorup
TEL. NO. RES. BUS. OCC. dredge worker
RESP. self and Blue Cross

DIAGNOSIS

HISTORY

fell from ladder at home, fract.shaft of left tibia near the junction of the middle and distal thirds

OCT 29 1952

x-Ray- Prov. left tibia Dr

NOV 24 1952

Hurts bad at top of plate. Fracture is solid. Try heat to area.

JAN 24 1953

Severe inflamed skin to Prov.

FEB 11 1953

To Prov. Abscess opened. Plate out. Wound dressed. Block on edge.

FEB 1 8 1953

MAR 2 1953 Dry crust. Improving.

MAR 6 1953

APR 1 1953 Dry crust. Heal in lower thigh & ankle.

APR 1 6 1953

Enfermin no [illegible]

APR 2 5 1953

Referred to Doctor for [illegible] graft [illegible] [illegible] & painful

JUN 1 9 1953

AUG 1 5 1953

JAN 9 1954 Healed.

FEB 6 1954 OV.

[illegible] 1 0 [illegible] Hurt last ~~Thurs.~~ April 1st first day on job - working for US Engineer doing dredge work - has on the job coverage but thru Public Health. so will pay it himself

~~Has~~ severe tenosynovitis & marked crepitus. RE cast applied.

PLAINTIFF'S EXHIBIT No. 13

Campbell's
Operative Orthopedics

Editor
J. S. Speed, M.D.

Associate Editor
Hugh Smith, M.D.
Memphis, Tenn.

Second Edition

With 1141 Illustrations
Including 2 Color Plates

Volume I

St. Louis
The C. V. Mosby Company
1949

Operative Orthopedics

Compound Fractures

As previously stated, the object of treatment of fractures is the establishment of union in good position, and the restoration of maximum function to the injured parts. In the accomplishment of this purpose in compound fractures, the treatment of the

Plaintiff's Exhibit No. 13—(Continued.)

wound and the prevention of pyogenic and clostridial infection assumes primary importance. The object of emergency treatment is the conversion of a contaminated wound to a clean wound, thereby promoting early healing of the soft tissues, and the conversion of a potentially infected open fracture to a healed, closed one. Treatment of the fractured bone is secondary to the prevention of infection.

The first consideration is the patient's general condition. Emergency measures (Chapter I) are frequently necessary to combat pain, hemorrhage and shock; thereafter, attention is directed to the local condition. From the time of injury until the patient is ready for the local preparation, the wound should be protected by a dressing and the extremity splinted.

In taking the history, one should note how, when, and where the injury occurred; in the examination, one should determine the extent and type of soft tissue wound, the existence of any vascular or neurologic damage, and should have roentgenograms made to show the extent and type of injury to the bone. In many cases, the true extent of soft tissue damage cannot be ascertained until surgical exploration is possible. Time, and the type and extent of soft tissue damage are two factors which have a direct bearing on the method of treatment.

Surgery should be carried out as soon as the patient's general condition will permit. Compound

Plaintiff's Exhibit No. 13—(Continued.)

fractures are emergencies. With the passage of time, the probability of infection increases rapidly. An elapse of twelve hours is usually considered the limit between a contaminated and an infected wound. The time limit is less in more extensive and severe wounds. In order to provide some yardstick to parallel the time rule, wounds may be classified as follows:

Type 1.—Small puncture wounds caused by a protrusion of bone from within out, or by a bullet passing from without in; i.e., minimum damage to soft tissue.

Type 2.—Wounds extensive in length and breadth, but with little or no avascular, or devitalized soft tissues and relatively little foreign material.

Type 3.—Wounds of moderate or massive size, with considerable necrosis of the soft tissues. The presence of foreign material increases the degree of severity.

It should be noted that the differentiation of wounds in the three types is based principally on the amount of avascular or devitalized tissue.

A proper evaluation of the wound, the time factor, and the efficiency of the debridement will determine the extent of bone surgery, the feasibility and extent of internal fixation, and whether primary closure or drainage of the wound is preferable.

The following treatment is based upon the premise that conditions for treatment are ideal; i.e., that

Plaintiff's Exhibit No. 13—(Continued.)

adequate splinting will be utilized to minimize the trauma of transportation; that patients will ordinarily arrive within twelve hours after the injury at a hospital equipped to provide adequate emergency treatment; that surgery will be effectually carried out; and that constant observation by a well-trained personnel can be assured during the post-operative period.

Local Preparation.

The area surrounding the wound is thoroughly cleansed with green soap and water, the wound remaining covered with a sterile dressing. With a sterile razor, the field is then shaved and the skin cleansed with benzine and ether. To prevent further contamination, all solutions must be applied in an ever-widening circle from the edges of the wound. The wound is thoroughly irrigated with copious quantities of saline solution. During irrigation, all portions of the wound, including the ends of the fragments, are exposed and gently massaged to remove as much extraneous material as possible. Mechanical washing of the wound is of far more importance in the prevention of sepsis than the application of antiseptic solutions; in fact, the majority of antiseptic solutions irritate the tissues and do actual harm. After application of the routine operating-room antiseptics to the skin around the wound, the field is draped.

Plaintiff's Exhibit No. 13—(Continued.)

Treatment of the Soft Tissues.

For small puncture wounds induced by indirect violence, the preliminary cleansing is usually sufficient. The serrated borders of the skin are excised, and the wound loosely closed. Probing in the wound, and the injection of antiseptic solutions are contraindicated, since these measures induce additional organisms into the wound and disseminate those already present. If a fragment of bone protrudes from the skin, the end is cleansed with ether and washed with saline solution. In such cases, the wound must frequently be enlarged to permit reduction of the fracture. The wound may also be enlarged to permit the use of internal fixation, if this is indicated.

Debridement is a term rather loosely applied in the American literature to cover the following procedure: exploration of the wound; excision of devitalized tissue; eradication and elimination of foreign material; repair of damaged structures. This procedure is applicable to the wound of type 2 and type 3 compound fractures, and must be carried out systematically and thoroughly. The superficial wound must be extended sufficiently for complete exposure of all of the involved deeper structures. On the other hand, dissection should be limited to the minimum requirements to prevent dissemination of the contamination and an unnecessary addition to pre-existing trauma. Beginning superficially with

Plaintiff's Exhibit No. 13—(Continued.)

the skin, excision of devitalized structures should proceed layer by layer to the depths of the wound, with due regard for essential anatomic structures, such as vessels, nerves, and tendons. The skin should be excised sparingly, keeping in mind the possibility of closure. All foreign material must be eradicated either by washing and lavage, or by excision of the adjacent tissue to which it clings.

Lacerations of tendons or nerves are repaired efficiently, but with less detail and precision than is observed in selective operative procedures. The necessity for care in handling of the soft tissues cannot be over-emphasized, however, as necrosis incident to excessive trauma provides an excellent medium for growth of bacteria. A minimal amount of catgut should be introduced into the wound. As a final step in the handling of the soft tissues, the wound is again thoroughly washed with copious quantities of saline solution.

Antibiotics are not a substitute for careful debridement. Hampton's observations of battle casualties support this view. He observed that penicillin will protect living tissue against the invasion of infection; that penicillin will not sterilize devitalized infected tissue which inadvisedly or of necessity remains in the wound; that it will not prevent septic decomposition of a contaminated hematoma, nor will it neutralize locally necrotizing enzymes in undrained parts. Wounds which are free of devital-

Plaintiff's Exhibit No. 13—(Continued.)

ized tissue, foreign material, and large hematomas are likely to heal without sepsis.

Treatment of the Bones.

The principles of proper handling of the periosteum and bones in selective surgical cases are outlined in the first of this chapter. Their application is even more important in compound fractures. Loose particles of bone are left in situ, as large defects between the fragments impair the progress of union. Small particles with their periosteum and soft tissue attachments intact may even act as small grafts and may possibly stimulate osteogenesis. Fragments of bone filled with foreign material, grease, or dirt, which cannot be thoroughly cleansed, provide an exception to this rule. Small fragments are removed in toto; the ends of the larger fragments are excised to clean bone.

The fracture must be reduced and immobilized. The method whereby this is accomplished will depend upon the bone involved, the type of the fracture, the efficiency of the debridement, and the patient's general condition. If it seems desirable to limit the trauma from surgery to a minimum, and the fracture is transverse, reduction may be accomplished manually, and a cast applied as for a closed fracture; the cast is then bivalved to allow inspection of the extremity. Compound fractures of the shaft of the humerus may be temporarily immobilized on an abduction humerus splint, to be followed by a hanging cast.

Plaintiff's Exhibit No. 13—(Continued.)

For the femur, skeletal traction with the extremity supported in a splint is often advantageous in maintaining proper alignment of the fracture, while providing for inspection of the wound. Before inserting the wires, the operator should change his gown and gloves, and completely redrape the field.

After the introduction of the sulfa drugs, and particularly the antibiotics, we advocated the use of metallic internal fixation in compound fractures, based upon essentially the same indications as observed in closed fractures, provided primary healing might reasonably be expected following closure of the wound. The use of metallic internal fixation is by no means a routine procedure; in a relatively large series of cases, however, the number of infections has been no larger than previously, reductions have been relatively anatomic, and in the majority, union has taken place at practically the same rate as in selective surgical cases. If infection or sepsis develops and external fixation must be partially removed to permit inspection and dressing of the wound, internal fixation maintains the reduction. Though drainage may persist and union progress slowly because of infection, one troublesome factor in the management of these cases is eliminated. In utilizing metallic internal fixation, one must be cognizant of its disadvantages; in the majority of cases, additional trauma will be created by exposure and stripping incident to the application of the fixation material. Regardless of how inert it may be, the

Plaintiff's Exhibit No. 13—(Continued.)

metal must be considered a material foreign to the normal anatomic structures. If sepsis ensues, draining sinuses will probably continue until the metal is removed. The use of internal fixation under unfavorable conditions is likely to lead to undesirable sequelae.

In compound comminuted fractures of the lower third of the tibia, with a fracture of the fibula at the same level, the plate and screws may be applied through a separate incision to the fibula, with care to prevent contamination from the compound wound. In fractures of both bones of the forearm, the same principle may be applied, i.e., stabilization of one bone may obviate the necessity of metallic fixation of the other fracture through a more contaminated wound.

Primary or Secondary Closure; Closed Plaster Method.

With the completion of debridement and reduction of the fracture, the question immediately arises as to the advisability of closing the wound, i.e., whether or not partial closure with drainage should be instituted, or whether the wound should be left completely open, and early healing prevented by the use of petrolatum gauze. Although no rule can be rigidly applied, the following suggestions are offered: In type 1 and type 2 wounds of less than twelve hours' duration, the wound is usually loosely sutured with silk and drains are omitted. The same

Plaintiff's Exhibit No. 13—(Continued.)

procedure is applicable to a few of the less severe type 3 wounds. As so aptly put by Hampton, complete closure of the wound is justified only when the "pabulum" of wound sepsis is nil. As an added safety factor, in the more severe injuries, drainage may be established by a cigarette drain or petrolatum gauze, either in the most dependent portion of the wound or through counter incisions. When the wound is of more than twelve hours' duration, or the soft tissues are so extensively damaged that devitalized tissue must, of necessity, be left in the wound, continuous drainage from the depths of the wound should be insured with petrolatum gauze. As a rule, type 3 wounds, or those of more than twelve hours' duration, should not be closed.

If surgical judgment dictates that there is some doubt about the feasibility of closing the wound, it is better to follow a conservative course by allowing unimpeded drainage from an open wound. Statistics from battle casualties of World War II have conclusively proved that, with the use of antibiotics, secondary closure of open wounds on the tenth to fourteenth day is practicable. Secondary healing of the wound should take place in 80 per cent of properly selected cases. By this method, the hazards of a continuously draining open wound, namely, sequestration of exposed bone cortex, sloughing of tendons, muscle, and fascia, reinfection of the wound with a mixed bacterial flora at dressings, and prolonged healing of the wound attended by excessive scar

Plaintiff's Exhibit No. 13—(Continued.)

formation, are obviated. In doubtful wounds, continuous drainage should provide a tremendous safety factor against pyogenic or clostridial infection. If the wound is clinically clean after ten to fourteen days, secondary closure may be instituted.

In civilian practice, the closed plaster method of treating compound fractures has a limited application, namely, severe type 3 wounds, usually of the hip and upper third of the thigh or shoulder. Shotgun wounds are notorious examples of this group. Because of the excessive amount of foreign material in the wound, the anatomic restrictions imposed upon surgery, and the excessive damage to the soft tissue structures, some degree of sloughing and sepsis is inevitable. Even without infection, the natural reparative and absorptive powers would hardly be able to cope with the foreign material and the devitalized soft tissue. This type of injury also presents a fertile field for anaerobic infection. In these cases, continuous drainage must ordinarily be maintained for a period of weeks or months.

After-Treatment.

The extremity must be thoroughly immobilized to insure rest for the injured tissues. Edema is minimized by elevation of the extremity and the provision of dependent drainage. A removable pressure dressing also facilitates the healing of the wound. Constant observation should be maintained that any disturbances or impairment in circulation or the

Plaintiff's Exhibit No. 13—(Continued.)

onset of pyogenic or gas infection may be promptly discovered.

Mixed antigas and antitetanus sera are routinely administered. As a precaution against anaphylactic reactions prior to injection, a small amount of the antitoxin should be introduced intradermally to determine whether the patient is sensitive to the sera. The value of prophylactic roentgen therapy or antigas serum is questionable. In massive type 3 wounds, the administration of a second dose of antitetanus serum after ten days may be advisable.

Penicillin is invariably administered in rather massive doses (p. 16) until all danger of sepsis has passed. For the reasons stated above, penicillin alone is not insurance against a pyogenic or gas infection. In combination with good surgery and surgical judgment, however, penicillin provides a tremendous safety factor in the prevention of stormy inflammatory processes.

PLAINTIFF'S EXHIBIT No. 24

Warren C. Hunter, M.D.
Physician - Pathologist
U. of O. Medical School
Portland 1, Oregon

Report of Consultation

Accession No.: S-52-1702 (USPHS Hosp., Seattle)

Physician: A. T. Morrison, Senior Surgeon.

Patient: Amos R. Morin.

Tissue: Microscopic section only.

Date Reported: April 13, 1954.

Hospital: USPHS Outpatient Clinic, Portland, Ore.

Address:

Date Received: April 13, 1954.

Gross Description:

On the slide bearing the above number are five sections, stained with hematoxylin-eosin. The slide is additionally identified by the patient's name, as given above.

Microscopic:

It is understood from a conversation with Dr. Morrison, who delivered the section to me personally, that the tissues represented in the sections came from the site of a compound fracture of a lower extremity some little time after the fracture occurred

and that these were removed at the time of an open reduction of the fracture.

Four of the tissues on this slide are bits of bone, with a little marrow only. There is neither inflammation nor necrosis of either bone or marrow.

The fifth and much the largest of the sections consists principally of connective tissue and fat, although at one margin there is a bit of callus and young trabeculated bone and at one other point there is a particle of bone embedded in connective tissue. The latter is not necrotic but its position makes one think that it may represent a tiny sequestrum from the fracture site in all probability. At times monocytes, lymphocytes and foreign type giant cells occur in the connective tissue but aside from these there is no suggestion of anything inflammatory at all. Parts of the connective tissue give evidence of recent formation. At one point a few skeletal muscle fibers have become incorporated in the connective tissue.

The question asked of me by Dr. Morrison is whether there is evidence of infection in this tissue. The answer is no; there is but little inflammation at all and this is not the type of reaction that one would expect to an infectious agent.

/s/ WARREN C. HUNTER,

WARREN C. HUNTER, M.D.

Request that enclosed copy be sent to Dr. Perrin.

PLAINTIFF'S EXHIBIT No. 25

March 10, 1954.

Dr. A. T. Morrison,
Public Health Service,
Court House,
Portland, Ore.

Re: Mr. Amos Morin.

Dear Dr. Morrison:

This patient reported to my office on the 8th of March, 1954, for a special examination.

Chief complaints at the present time:

1. Pain and weakness in the knees and the left leg.

2. Pain and discomfort, with drainage in the left lower tibia.

History:

This patient informs me that he originally suffered injuries on or about the 10th day of June, 1952, when he fell in coming down a ladder while painting his home in Portland, Ore., and as a result, suffered a compound fracture of both bones of the left leg. He was taken to the Physicians & Surgeons Hospital immediately where first aid treatment was rendered and his wounds were cleansed and dressed. After reviewing and evaluating the situation, it was decided to transfer him to the Marine Hospital in Seattle, Wash., which was done two or three days later and there an open reduction and thorough

Plaintiff's Exhibit No. 25—(Continued.)

cleansing and inspection of the compound wounds were carried out. He states he was in a cast for some time, and he stated that the wound became inflamed and an inspection window was cut in the cast. One month after this, the cast was cut off and the wound was completely healed but the bone position was not considered satisfactory according to his statements to me, and he was again taken to surgery, and this time a sliding bone graft and the application of a metallic plate was carried out. He was there for approximately 16 weeks. Then, due to the fact that he wished to return home he left the hospital against advice and came to Portland. He was then taken to Providence Hospital and was under the care of Dr. Cherry and remained in Providence Hospital for about four weeks. At that time, the plate from his tibia was removed due to the fact that it was either bent or causing some local irritation. A cast was reapplied to his leg, and the bones were realigned and he was sent home, however, leg bothered him and he was taken the next time to St. Vincents Hospital where he remained for a period of about one week for dressings, hot applications, etc. Finally, due to the fact that the condition did not appear to be healing normally and looked like a long drawn-out case, he was transferred to the Veterans Hospital in February of 1953, where he remained for about one year for treatment. During his treatment there, numerous skin grafts were applied to the denuded area over the bone, and he had several operations approximately twelve or thirteen

Plaintiff's Exhibit No. 25—(Continued.)

in all. He has now been out of the hospital for some time, and of course, has the weakness in his legs due to the inactivity and still has a little drainage from the bone on the left leg.

Past History:

This patient also suffered an injury to his lumbar spine which was treated by the application of a body cast and by bed rest. The patient informs me that there was a compression fracture of the 2nd lumbar vertebra, but that the back does not bother him to any extent at the present time. He states he has had no previous operations. He has had a Duodenal Ulcer which has given him some trouble but seems to have cleared up under treatment about four years ago. The rest of his systematic questionnaire was essentially negative from an orthopedic standpoint.

Examination:

This patient is 45 yrs. of age, he walks with a slight left-leg limp. Examination of his head and neck revealed no evidence of any pathology there. His upper extremities were within normal limits. His back motions revealed a little tenderness and pain in the lumbar area, and there is some restriction on forward and lateral bending in this area. Points of maximum tenderness appeared to be in the mid lumbar section. His hip motions approached normal. His straight leg raising tests approached

Plaintiff's Exhibit No. 25—(Continued.)

normal. His reflexes were active and equal. Examination of his lower extremities revealed donor sites of numerous skin grafts, the split-thickness type from the left thigh. There is a healed large scar on the calf of the left leg from which a pedicle skin graft was taken. Examination of his left leg reveals a slight drainage from the wound in the lower anterior portion of the leg which appears to be directly connected with the bone. Numerous skin grafts have been applied to this area, but there is one denuded section which is still unhealed. In general, the alignment of the leg appears to be quite satisfactory. There is a slight tendency toward inward bowing, but this is not enough to cause any definite disability. The movements in his ankle approached normal and he complains of no pain or swelling there. Pressure over the fracture site of his tibia is not especially uncomfortable. No other pathology was noted at the time of this examination, other than a slight atrophy of the muscles incident to his trauma and the disuse of his leg.

Comment:

In my opinion this patient evidently suffered a rather marked compression fracture of the lumbar vertebra which at the present time shows some permanent wedging and fairly solid bone consolidation. There is no other noteworthy change seen in this area, other than minimal arthritic changes which are present on the anterior projection of the x-rays

Plaintiff's Exhibit No. 25—(Continued.)

chiefly. The second and major difficulty in this instance is the old compound fracture of the left tibia and fibula, at the junction of the lower third with the upper two-thirds of the bone, complicated by osteomyelitis, and associated with a fracture of the shaft of the fibula just beneath the upper limits of the shaft. The present situation indicates that there is no marked activity than a small sequestra which appears to be present in the lower portion of the wound, and which I believe is the source of his present drainage. The shaft shows fairly normal consistency, except of course, at the area of the fracture and the healed section. Good solid bony union has taken place across the fibula and the tibia at this level. The fracture in the upper shaft of the fibula is completely healed. The ankle mortise is tilted approximately 10 degs. inward on account of the slight inward bowing of the tibia.

It is my feeling that this man's treatment has followed the pattern which is quite common in severe injuries such as his, and that unfortunately he developed some osteomyelitis which is likewise a fairly common incident in traumatic compound fractures. At the present time, I think the persistence of the drainage is probably due to the small sequestrum which is visible in the lower portion of his wound and which will probably be extruded spontaneously if it is not curetted out before that time. The disability in his leg I think will be greatly lessened when the wound heals, and aside from the

Plaintiff's Exhibit No. 25—(Continued.)

possibility of future injury, I think that this man can probably carry on some work. However, if he is going to work at the present time, I feel that there should be some allowance made for the fact that he still has a chronic osteomyelitic process, with a small sequestram in the lower portion of the wound.

Very truly yours,

RICHARD F. BERG, M.D.

RFB:es

[Title of District Court and Cause.]

DOCKET ENTRIES

1953

Nov. 17—Filed complaint.

Nov. 17—Issued summons—to Marshal.

Nov. 19—Filed summons with Marshal's return.

1954

Jan. 15—Filed answer.

Feb. 23—Entered order setting for pre-trial conference Apr. 19, 1954.

Apr. 19—Entered order setting for pre-trial conference May 3, 1954.

May 5—Filed 3 petitions for issuance of subpoenas duces tecum.

May 17—Filed and entered 3 orders for subpoena duces tecum.

1954

May 17—Issued 3 subpoenas duces tecum—to Marshal.

May 24—Record of hearing in response to subpoena duces tecum.

May 25—Filed 3 subpoenas duces tecum with Marshal's return.

May 28—Filed deposition of C. O. Schneider.

July 1—Entered order setting for trial on July 15, 1954.

July 7—Filed deposition of Lee A. Craig for pltf.

July 13—Issued subpoena—2 copies—to pltf's. atty.

July 14—Filed motion for subpoena duces tecum.

July 14—Filed petition for subpoena duces tecum.

July 14—Filed and entered order for issuance of subpoena duces tecum.

July 14—Issued subpoena duces tecum, handed to Marshal.

July 15—Filed subpoena duces tecum with Marshal's return.

July 15—Filed subpoena with Marshal's return.

July 14—Entered order resetting cause for trial July 21, 1954.

July 21—Filed and entered pre-trial order.

July 21—Record of trial before the Court.

July 22—Record of trial before the Court.

July 23—Record of trial before the Court submitted.

July 23—Filed exhibits: Plaintiff's 1, 2a to h, 3, 4a to j, 5a and b, 6, 7, 8, 10 to 16; Defendant's 17, 18, 20, 21a and b, 23a to e, 24, 25, 26.

Aug. 3—Record of trial (arguments).

1954

Aug. 4—Record of opinion.

Aug. 4—Filed opinion.

Aug. 10—Filed and entered findings of fact and conclusions of law.

Aug. 12—Filed praecipe U. S. Atty. for certified copy of judgment. Issued 8-27-54.

Aug. 19—Record of hearing on attorney fees and entered order allowing 20%.

Aug. 20—Filed and entered additional and supplemental Findings of Fact.

Aug. 26—Filed and entered judgment for plaintiff for $45,000.00 general damages, $4,711.27 special damages, $58.98 costs and allowing $9,942.25 attorney's fees out of recovery.

Aug. 26—Filed cost bill.

Aug. 27—Filed notice to tax costs.

Sept. 20—Filed stipulation re cost bill.

Sept. 20—Filed and entered order to substitute cost bill.

Sept. 20—Filed substitute cost bill. Costs taxed at $48.98.

Sept. 20—Filed praecipe U. S. for cert. copy of substitute cost bill. Issued 9-21-54.

Oct. 11—Filed transcript of proceedings, July 21, 22 and 23—Aug. 19, 1954.

Oct. 25—Filed notice of appeal by defendant and copy mailed to Ryan & Pelay.

Dec. 2—Filed motion for order allowing U. S. 90 days from date notice of appeal to file and docket appeal.

1954

Dec. 2—Filed and entered order allowing U. S. 90 days from date notice of appeal to file and docket appeal.

1955

Jan. 12—Filed designation of contents of record on appeal.

Jan. 14—Filed stipulation for order to send exhibits to Court of Appeals.

Jan. 14—Filed and entered order to send exhibits to Court of Appeals.

[Title of District Court and Cause.]

CERTIFICATE OF CLERK

United States of America,
District of Oregon—ss.

I, F. L. Buck, Acting Clerk of the United States District Court for the District of Oregon, do hereby certify that the foregoing documents consisting of Complaint; Answer; Pre-trial order; Memorandum of Judge Claude McColloch; Findings of Fact and conclusions of law; Additional and supplemental findings of fact; Order re: attorneys' fees; Stipulation re: "Substitute Cost Bill"; Order re: "Substitute Cost Bill"; Substitute cost bill; Judgment; Notice of appeal; Motion to extend time for docketing appeal; Order extending time for docketing appeal; Designation of contents of record on appeal; Stipulation to forward exhibits to Court of Appeals; Or-

der to forward exhibits to Court of Appeals; and Transcript of docket entries, constitute the record on appeal from a judgment of said Court in a cause therein numbered Civil No. 7260, in which the United States of America is the defendant and the appellant and Amos R. Morin is the plaintiff and the appellee; that the said record has been prepared by me in accordance with the designation of contents of record on appeal filed by the appellant, and in accordance with the rules of this Court.

I further certify that there is also enclosed a copy of the transcript of proceedings of July 21, 22 and 23, 1954, and August 19, 1954. The exhibits will be forwarded under separate cover at a later date.

In Testimony Whereof, I have hereunto set my hand and affixed the Seal of said Court in Portland, in said District, this 18th day of January, 1955.

[Seal] /s/ F. L. BUCK,
Acting Clerk.

[Endorsed]: No. 14627. United States Court of Appeals for the Ninth Circuit. United States of America, Appellant, vs. Amos R. Morin, Appellee. Transcript of Record. Appeal from the United States District Court for the District of Oregon.

Filed January 19, 1955.

/s/ PAUL P. O'BRIEN,
Clerk of the United States Court of Appeals for the Ninth Circuit.

In the United States Court of Appeals
for the Ninth Circuit

No. 14627

UNITED STATES OF AMERICA,
Appellant,

vs.

AMOS R. MORIN,
Appellee.

STATEMENT OF POINTS UPON WHICH APPELLANT INTENDS TO RELY ON APPEAL

Appellant respectfully submits the following Statement of Points upon which appellant intends to rely on appeal:

1. The evidence in the case fails to establish that there was any deficiency in the treatment accorded appellee in the Physicians & Surgeons Hospital at Portland, Oregon.

2. If there was a deficiency in the treatment accorded appellee as charged, the evidence fails to establish that it was the direct and proximate cause of appellee's osteomyelitis, or the residual disability, pain and suffering resulting therefrom.

3. The Court erred in finding that appellant, in treating appellee, did so in a negligent, careless manner proximately causing injuries to appellee, by failing to render appellee immediate, adequate and proper medical and surgical treatment, cleanse

debridement and closure of wounds at the site of the fracture of the left tibia.

4. The Court erred in finding that appellant, in treating appellee, failed to exercise the degree of care and skill ordinarily exercised by physicians in Portland, Oregon, and like communities in the treatment of the comminuted compound fracture of the left tibia.

5. The Court erred in rendering a verdict in favor of appellee and against appellant because there was no substantial evidence to support said verdict.

6. The District Court erred in making and entering its Judgment, dated August 26, 1954, herein appealed from, by ordering, adjudging and decreeing judgment in favor of appellee herein and against the United States of America, appellant herein, for the reasons set forth in specification of errors Nos. 1 to 5, inclusive, herein designated.

7. That the verdict as rendered by the District Court was excessive.

8. The District Court erred in finding that appellee would be required to undergo further operations.

Dated at Portland, Oregon, this 26th day of January, 1955.

C. E. LUCKEY,
United States Attorney
for the District of Oregon;

/s/ VICTOR E. HARR,
Ass't. United States Attorney
Of Attorneys for Appellant.

Service of copy acknowledged.

[Endorsed]: Filed February 1, 1955.

[Title of Court of Appeals and Cause.]

STIPULATION WITH RESPECT TO PRINTING OF THE RECORD

Whereas there are in this cause a substantial number of X-rays and a substantial number of documentary exhibits (including hospital records, payroll and employment records, and a textbook of surgery) which would be very expensive to print, but which each party on brief and in argument will wish to refer to;

It Is Hereby Stipulated by and between the parties, through their attorneys of record, subject to the approval of the Court, that all of the exhibits referred to in Paragraph 12(b) of the Stipulated Designation of Contents of Record on Appeal herein may be considered by this Court in their original form and need not be printed in the record.

The exhibits to which this stipulation refers are numbered Exhibits 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 14, 15, 16, 17, 18, 20, 21 and 23.

Dated this 26th day of January, 1955, at Portland, Oregon.

C. E. LUCKEY,
United States Attorney
for the District of Oregon;

/s/ VICTOR E. HARR,
Ass't. United States Attorney
of Attorneys for Appellant.

/s/ JOHN D. RYAN,
Of Attorneys for Appellee.

It Is So Ordered:

.....,
Judge.

[Endorsed]: Filed February 1, 1955.